NBHP

Network of Behavioral Health Providers

The Greater Houston Community Coordination of Care Initiative

Consensus Recommendations & Pilot Project Implementation Report

June 2019

We would like to thank the Episcopal Health Foundation for their generous support of the Community Coordination of Care Initiative.

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EXECUTIVE SUMMARY

Care coordination, which involves multiple entities working together to manage and organize a patient's care "delivers health benefits to those with multiple needs, while improving their experience of the care system and driving down overall health care (and societal) costs."[i] However, the long-standing fragmented and "siloed" nature of the health care system in our community has presented a significant challenge for organizations seeking to provide high-quality care, as well as for those who must navigate through this complex system.

In addition, various barriers—such as the lack of aligned reimbursement structures and misunderstandings about privacy laws—have made it difficult for providers to fund appropriate staff and systematically share patient information in order to coordinate care. A combination of these challenges has helped create an inefficient system where community-based services provided to the same consumers are routinely duplicated and acute-care and higher-cost services, such as hospitals and emergency rooms, are routinely misused.

But perhaps the greatest obstacle to care coordination and improving clients' overall health is the lack of focus on social determinants of health. Social determinants of health (SDOH) are conditions in the environments where people are born, live, learn, work, play, worship and age that can have a significant impact upon a person's health outcomes, risks and overall quality of life.[ii] There are five major SDOH areas, each of which has several underlying factors. They are more fully detailed in Box 1.

Box 1

5 SDOH Categories

Economic Stability
- Employment
- Food Insecurity
- Housing Instability
- Poverty

Education
- Early Childhood Education and Development
- Enrollment in Higher Education
- High School Graduation
- Language and Literacy

Social & Community Context
- Civic Participation
- Discrimination
- Incarceration
- Social Cohesion

Health and Health Care
- Access to Health Care
- Access to Primary Care
- Health Literacy

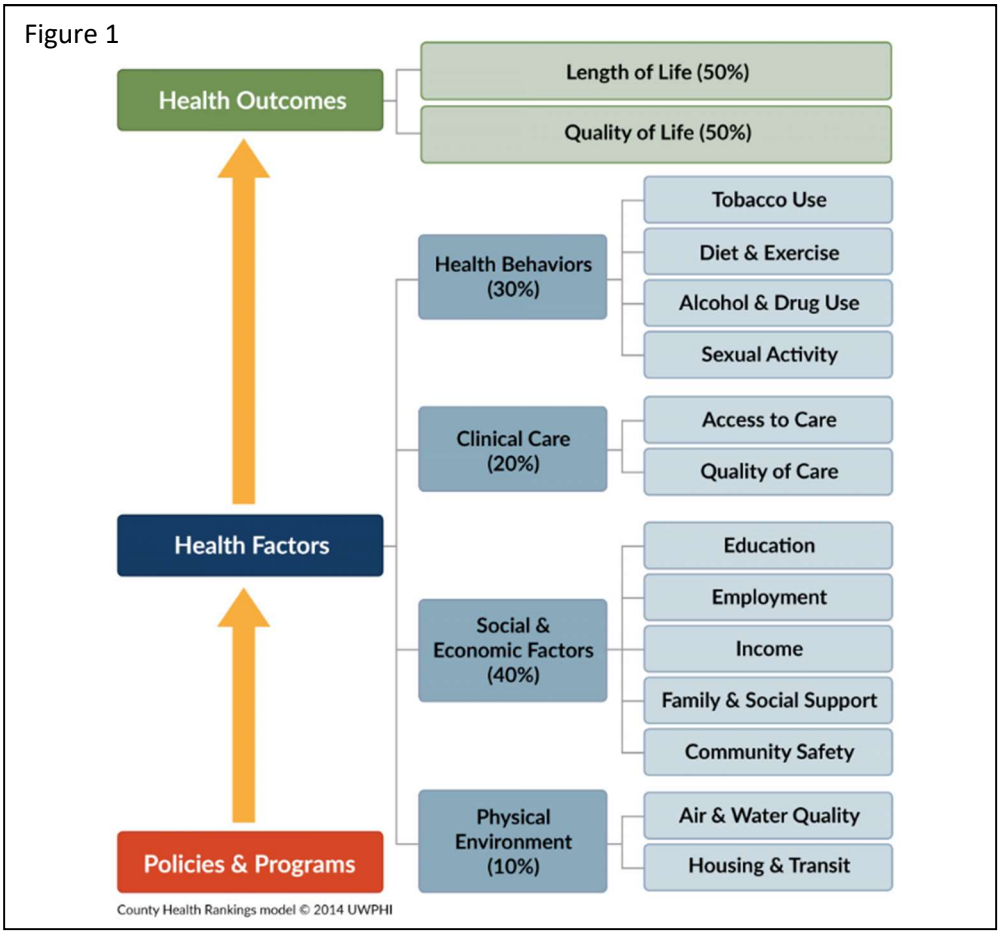
Neighborhood and Built Environment
- Access to Foods that Support Healthy Eating Patterns
- Crime and Violence
- Environmental Conditions
- Quality of Housing

Source: Healthy People 2020

These factors have the dominant influences on health outcomes, while only about 20% of health outcomes are based upon clinical care (see Figure 1).[iii] Despite this, the vast majority of health care expenditures are for clinical care and "planning, financing, delivery of health care, public health and social services often occur in isolation."[iv]

While clinical care will remain an important component of patient health, we can no longer afford to treat it as the ***only*** component. Health interventions must be broadened to encompass long-ignored socio-economic factors because "[i]t is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change."[v] Failing to address these issues means patients will not receive the totality of care they need in order to improve their overall health and quality of life.

Figure 1



The Network of Behavioral Health Providers created the Community Coordination of Care (C^3) Initiative to review and determine how these community challenges can be addressed. The C^3 Initiative convened medical, behavioral health and social service organizations and engaged consumers, governmental entities and academia to develop recommendations to facilitate coordinated care, as well as implement a coordinated care pilot project based upon this framework. A brief overview of the recommendations and pilot project are below.

Consensus Recommendations

For a Local Agency:

- Implement a comprehensive database of social service and health care resources that:
  - includes support groups, advocacy organizations, and recreational/volunteer opportunities;
  - includes detailed program information on each agency (e.g., whether or not it is accepting new clients, forms of insurance accepted, eligibility criteria, etc.);
  - is available for the public to access; and
  - is routinely updated, including through feedback from end-users.

For Local Health Care, Behavioral Health and Social Service Provider Organizations:

- Incorporate into operations practices that include:
  - providing transportation for clients to and from their location to other providers;
  - holding resource fairs for consumers and including peer support specialists/recovery coaches as resources;
  - holding classes for patients and/or developing a handbook that explains how to navigate the health care system locally;
  - striving to hold flexible, non-traditional hours to meet the needs of working clients;
  - providing a quarterly training for case managers and other frontline staff regarding available community resources; and
  - educating staff and promoting inclusivity as it relates to programs and resources available based upon immigration status.
- Integrate primary care, behavioral health and social services and, to the extent possible, make those services available on-site.
- Develop and adopt a universal client consent form for purposes of data sharing across agencies.
- Whether through formal screening or another appropriate method, assess both the social-environmental and health (including behavioral health) needs of patients.

For the United States Congress:

- Provide funding and/or financial incentives for behavioral health providers to implement Electronic Health Records.
- Pass legislation requiring the provision of high-quality, affordable health care coverage to all U.S. residents.

For the United States Department of Health and Human Services:

- Develop and issue a Health Insurance Portability and Accountability Act-compliant data sharing Memorandum of Understanding template to assist organizations seeking to share client data.

For Appropriate Federal and State Regulatory Agencies:

- Monitor and ensure compliance with the Mental Health Parity and Addiction Equity Act.

For the Texas Legislature:

- Expand Medicaid as set forth under the Affordable Care Act or provide alternative high-quality, affordable health coverage options.

- Require training and other provisions to ensure that state-funded health care services are trauma-informed.
- Increase funding to expand the number of psychiatric residency positions.
- Increase funding to expand the number of available inpatient psychiatric and detoxification beds.
- Fund the provision of behavioral health counseling services on all public school campuses.

For the Texas Legislature and Local Government:

- Increase funding for services that promote prevention and early intervention related to physical health, behavioral health and socio-economic issues.
- Provide funding and other incentives for health care, behavioral health and social service agencies to coordinate care.
- Increase funding for community-based mental health and substance use disorder services.

For Local Governments:

- Increase funding for public health services.

For Health Care Payers:

- Prioritize the widespread implementation of a global payment reimbursement model that is value-, outcomes- and risk-based.
- Reimburse for navigation and coordinated care/treatment planning services under the current Fee-for-Service model.
- Reimburse for prevention-based activities—such as screenings—as well as the services that address socio-economic factors under the current Fee-for-Service model.
- Reimburse for services provided by non-clinical staff, such as peer support specialists, Community Health Workers and case managers.
- Work to expedite credentialing for providers to serve on insurance panels.
- Ensure full integration of physical and behavioral health services.

For Medical and Clinical Schools:

- Strengthen social determinant of health curriculum and education and ensure that all students receive this education, including through continuing education opportunities.

For Philanthropic Organizations:

- Prioritize direct services grant funding for agencies that collaborate to provide patients with coordinated care.

Pilot Project Overview

The pilot project target population will be adults and children who live with their families and have a diagnosable mental illness, a need for at least one social service and have a household income at or below 200% of the Federal Poverty Level. Based upon data overlays of communities with high social needs, high numbers of adults reporting mental distress and the availability of various community resources, the project will target eligible individuals who live in Spring Branch/Northwest Houston and Fifth Ward/Northeast Houston.

The key elements of the pilot project will include: 1) A network of primary care, mental health, substance use disorder and social service providers that will provide needed services to pilot project participants; 2) An electronic platform that allows participating organizations to share participant data, develop joint care plans and communicate regarding participant progress; and 3) Care coordinators who will help remove barriers that prevent participants from accessing needed services.

The pilot project will be based upon the Pathways Community HUB Model and use the "No Wrong Door" approach to ensure that participants can enter the program through any of the participating organizations or care coordinators. Participants will be required to consent to share their health (including behavioral health) and social service data with other pilot organizations. All participant data will be entered into the shared platform. Participant baseline functionality will be determined through use of the Daily Living Activities-20 assessment, which also will be administered periodically to determine participant progress.

The pilot project is expected to launch in late Summer/early Fall of 2019 and serve approximately 300 individuals over the 2-year period.

COMMUNITY COORDINATION OF CARE (C^3) INITIATIVE

INITIATIVE OVERVIEW

From its inception, the Network of Behavioral Health Providers (NBHP)—a collaborative of over 40 mental health and substance use disorder service providers in the greater Houston area—has focused on improving access to care for the population served by the local behavioral health system (***NOTE:*** Behavioral health refers to both mental health and substance use disorder). Due to the long-recognized and much discussed absence of care coordination across physical health, behavioral health and social services in the greater Houston area, the Houston Recovery Center's Coordinated Care Planning Team asked the Network of Behavioral Health Providers to convene community partners and facilitate the dialogue needed to develop a coordinated care model.

In January 2018, the Network of Behavioral Health Providers (NBHP) received a grant from the Episcopal Health Foundation to engage in planning to develop a coordinated care system that would integrate medical, behavioral health and social services to ensure that patients receive whole-health care (***NOTE:*** Patient, client and consumer will be used interchangeably throughout this report).

A kickoff meeting for the Community Coordination of Care (C^3) Initiative was held on April 10, 2018 at the United Way of Greater Houston. The meeting convened over 80 individuals representing dozens of primary care, behavioral health and social service organizations, as well as governmental and funder entities. Following the kickoff, over 60 organizations committed to participate in the initiative and move forward the following goals and deliverables:

Goals

- To create the blueprint for a coordinated, system-wide, person-centered continuum of care that integrates medical, behavioral health and social services while addressing the social determinants of health; and
- To develop a pilot a project focused on improving client and community outcomes, reducing service duplication, maximizing resource efficiency and generating cost savings.

Deliverables

Issue a report that identifies the necessary landscape for a coordinated system of care, as well as the plan for the coordinated care pilot project, including:

- Recommendations regarding the policy and system changes necessary to support implementation and sustainability; and
- A description of the pilot project implementation plan, including the target population, case management integration plan and shared electronic platform.

Initiative Structure

The C[3] Initiative was overseen by a Steering Committee of 14 members representing primary care, mental health, substance use disorder and social service providers. The Steering Committee membership can be found in Appendix A.

The C[3] Initiative Workgroup, comprised of representatives of over 60 organizations, was the "working arm" of the initiative. The full list of organizations that participated in the workgroup can be found in Appendix B. Throughout the process, the full workgroup met on two occasions: 1) for the Mid-Year Retreat to review the data that had been gathered, make preliminary decisions regarding the pilot project and begin prioritizing recommendations, and 2) for the Final Retreat, at which all of the recommendations and elements of the pilot project were finalized. However, the majority of the workgroup members served on one or more of four established committees that met on a monthly basis to collect and discuss the data to be presented to the full workgroup.

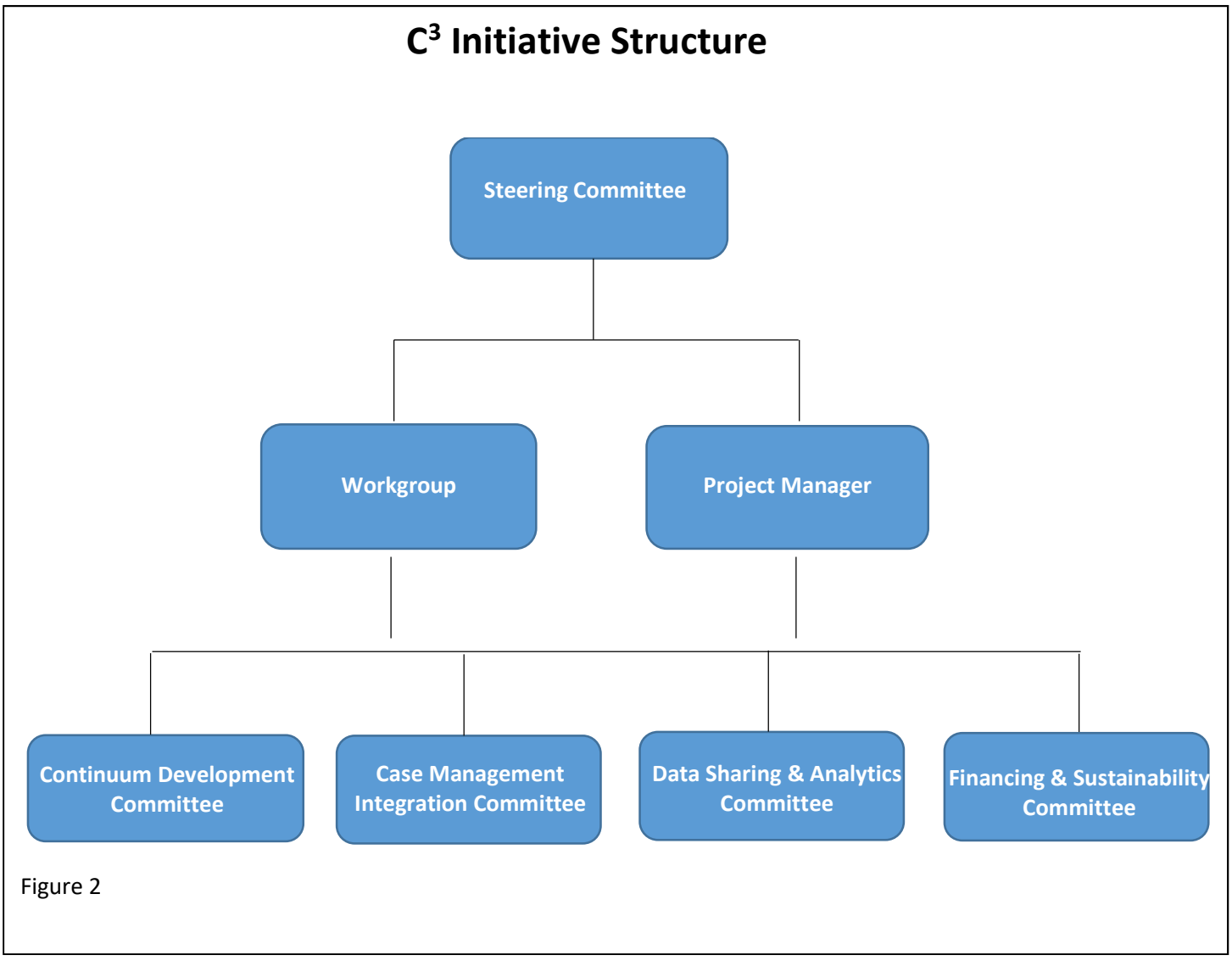


Figure 2

These four committees included the:

- **Continuum Development Committee,** which made recommendations regarding the target population for the pilot project and the continuum of services needed to serve the pilot project participants;
- **Case Management Integration Committee,** which developed the pilot project case management integration plan that will ensure that pilot project participants receive coordinated and integrated care among multiple agencies;
- **Data Sharing & Analytics Committee,** which made the recommendation regarding the Data Sharing & Care Coordination Platform that agencies participating in the pilot project will use; and
- **Financing & Sustainability Committee,** which merged with Mental Health America of Greater Houston's Integrated Health Care Initiative Financing Workgroup and explored ways to expand the utilization of reimbursement structures that support care coordination and integrated health care.

The committees also reviewed gaps in services and coordination barriers and vetted the consensus recommendations that will be discussed in further detail later in this report. In conjunction with the Steering Committee, the committees also developed the following Core Values that would guide the work of the initiative:

- The C^3 Initiative will ensure collaboration and connectedness across all types of providers of services to ensure a holistic and systemic system of care.
- The C^3 Initiative will be person-, family- and community-centered, tailoring and aligning available services to compassionately meet their unique needs.
- The C^3 Initiative will focus on quality, effectiveness and efficiency with actionable solutions that improve service delivery and bring value to the community.
- The C^3 Initiative will be culturally- and linguistically-competent, reflecting the diversity of Houston/Harris County.
- The C^3 Initiative will advance a "No Wrong Door" approach that allows consumer entry at any point, while promoting prevention and early intervention.
- The C^3 Initiative will be data-driven and outcomes-based with continuous quality measures.
- The C^3 Initiative will be proactive, cutting edge and innovative in its solutions, drawing upon national best practices and an intimate knowledge of community culture.

KEY FINDINGS

Working together with the Steering Committee, workgroup and committees, the Project Manager led several information-gathering activities that formed the basis for the development of the consensus recommendations and pilot project elements. Throughout this process, the C^3 Initiative engaged hundreds of individuals and more than 100 organizations in this work.

Community Survey

The Steering Committee and committees developed a survey to assess the care coordination activities in which primary care, behavioral health and social service organizations are involved, review gaps in services and determine other barriers to care coordination. The survey was first disseminated in July 2018, and final responses were received in August 2018. 126 respondents from more than 75 agencies completed the survey. A full list of the organizations that responded to the survey can be found in Appendix C.

Because social determinants of health (SDOH) play such a critical role in overall health and wellbeing, survey respondents were asked about their assistance with social services. 85% said they assisted clients with social services—either directly or through referrals. The top social services with which respondents assisted clients were benefits/insurance eligibility, transportation, food, and housing. The full distribution of services can be found in Figure 3.

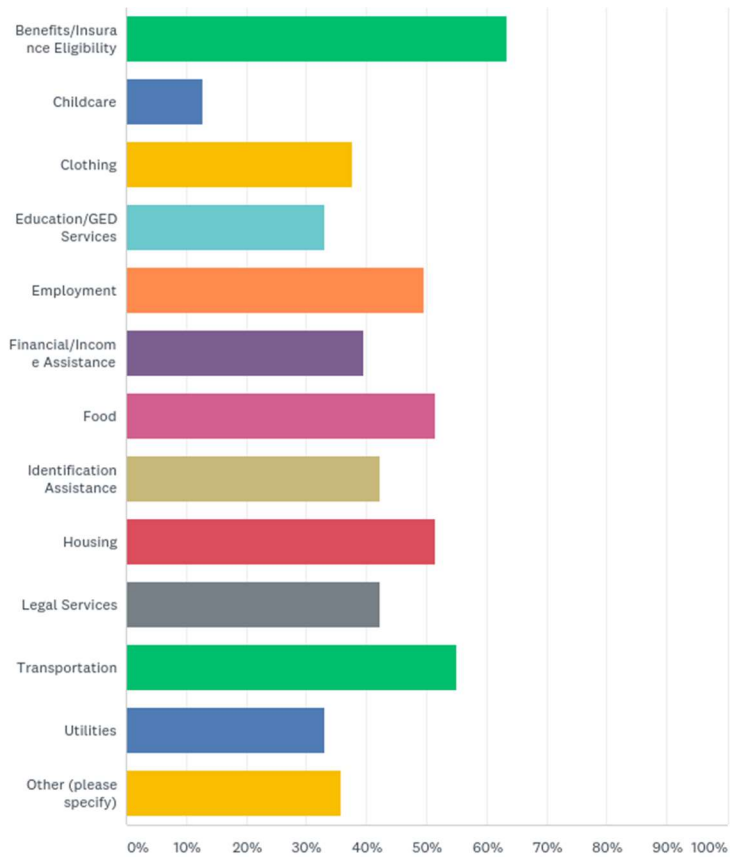


Figure 3

The survey also asked about barriers to coordination and gaps in services. Many felt that a lack of available community resources made coordination difficult, with client lack of transportation being the most-cited. Respondents also discussed consumer difficulty in navigating complex and fragmented systems. Also mentioned were limited data sharing and lack of trust between agencies; limited staff time available to coordinate care due to lack of reimbursement; and client issues, such as lack of financial resources, health coverage, literacy and legal immigration status.

The lack of data sharing among organizations was one of the biggest barriers to coordination. Without the ability to see where else a patient is receiving services and what those services are, managing client care across these diverse systems is incredibly difficult. While the Health Insurance Portability and Accountability Act (HIPAA) was sometimes cited as a barrier to data sharing, more respondents recognized that a bigger barrier was actually provider misinterpretation of HIPAA, 42 CFR Part 2 (substance use disorder privacy statute) and other privacy laws.

Lack of client consent and lack of uniformity/interoperability among provider platforms also were mentioned. In fact, the complexity of moving toward uniformity was evidenced by the fact that just over half of respondents used an electronic platform, and of those, very few were using the same systems (see Figure 4).

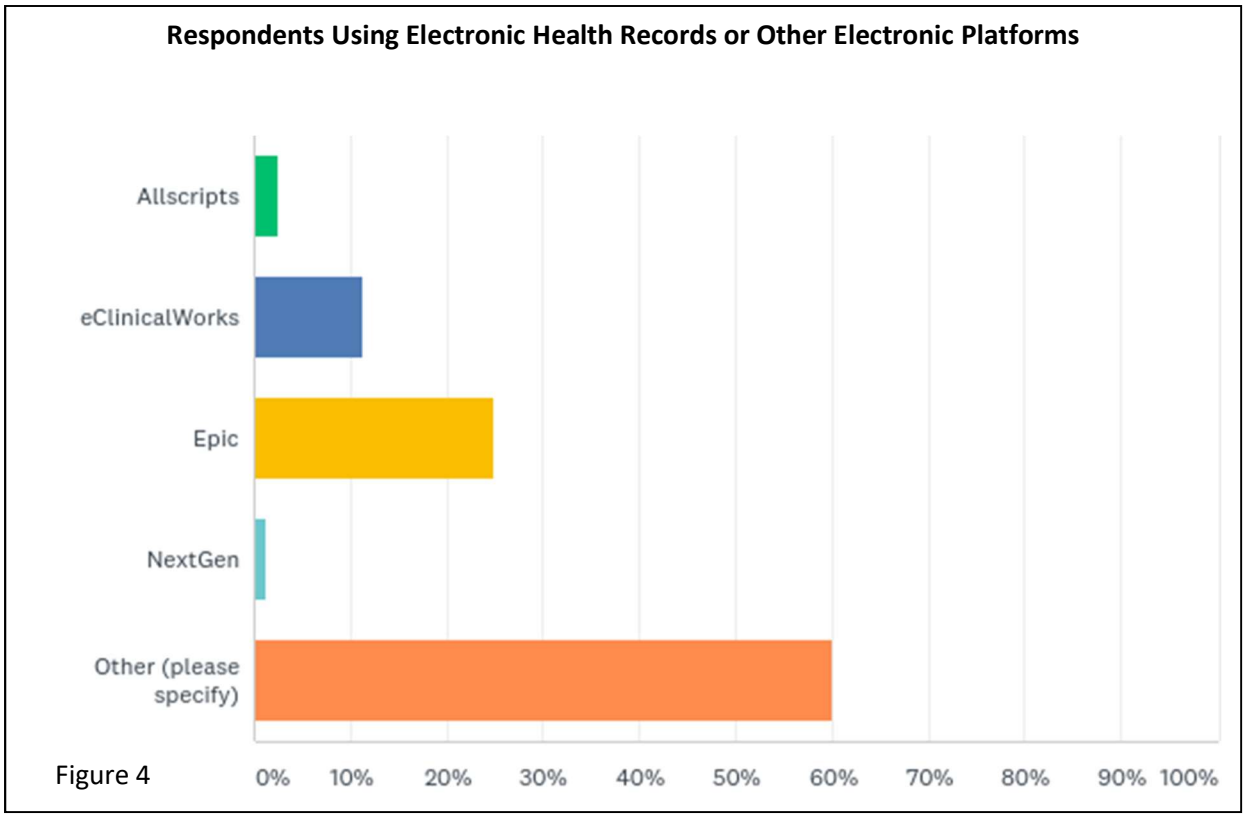


Figure 4

Survey participants also mentioned a number of gaps/barriers in obtaining medical, behavioral health and social services. These included: a limited number of providers available that served indigent populations or those with Medicaid; long waiting times, especially for specialty care and behavioral health care; limited access to medications and Medication Assisted Treatment; the lack

of detoxification and inpatient psychiatric beds, particularly for children and adolescents; lack of trauma-informed services; a lack of social services such as transportation, housing and vocational services, including for those with criminal backgrounds; and an overall deficit in linguistically- and culturally-competent services.

Respondents felt that some of these issues could be addressed through reimbursement for services that currently are not billable. These services include care coordination and non-medical case management services, transportation and services provided by Community Health Workers. Many also advocated moving to a global reimbursement system that encompasses funding for all the health (including behavioral health) and social services that a client needs in order to address these issues.

Other non-financial ways to facilitate care coordination included expanding access to health coverage, integration of physical and behavioral health and social services, instituting a universal intake process and instituting a universal Electronic Health Record (EHR) or platform.

Confidential Interviews

In August and September 2018, the Project Manager conducted confidential interviews with 30 CEOs and other high-level executives who work in health care, social services, academia and government regarding how the current landscape of care coordination and addressing social determinants in Houston/Harris County can be improved. A full list of interviewees can be found in Appendix D.

Most of the interviewees felt that while there are pockets of excellence in the greater Houston area, the health care system as a whole isn't effectively addressing SDOH. Although some thought that it was primarily the health care system's job to ensure their patients receive the services necessary to address SDOH, the majority said that all of the systems need to work together in order to accomplish this.

"In order to improve health outcomes, [health providers] have no choice but to participate in [social determinant] work."
—Governmental Organization

Screening for SDOH generally was looked upon positively, and many felt that some uniformity in screening questions was needed across organizations, as well as natural points of contact to better target screening. (i.e. screening children in schools). However, others felt that screening would be pointless if there were no resources in the community to which to refer people and if there is no well-integrated handoff process. Finally, some interviewees expressed that clinicians in the health care system must be better trained to demonstrate more understanding and sensitivity toward the patient population, particularly the indigent.

"[Some clinicians] don't realize how hard it may be for a patient to go to a specialty provider or to follow their meal plan [due to socio-economic factors]."
–Health Care Organization

Interviewees made observations similar to those of the survey respondents regarding barriers to care coordination and offered suggestions about how those can be overcome. Many felt that having organizational leadership that has the will to coordinate and collaborate with other agencies is important. Others suggested an administrative position at one agency that coordinates care with all of the others. Many cited the need for a comprehensive, well-vetted database of community resources. Some promoted the idea of service integration by recommending the co-location of social services with health and behavioral health providers and/or having multipurpose centers in every community that provide the opportunity to access health care, behavioral health, financial education, food and other services in one location.

"We tend to duplicate and replicate, but not coordinate enough."
—Health Care Organization

As far as incentives to promote care coordination, interviewees believed that foundations and governmental entities can set the expectation of care coordination by tying that to their funding. A performance-based payment system in which funding was tied to outcomes was viewed as another potential incentive. Some mentioned that organizations whose mission is to promote public health and well-being should want to coordinate care in order to further their mission, increase their capacity, serve more people in a more efficient way and reduce costs. Finally, others felt that as the evidence-base of care coordination and addressing SDOH continues to build—demonstrating the payoff—more organizations would choose to adopt those systems.

"We are still delivering more (high-level care) because we have less (lower-level care)"
–Behavioral Health Organization

While a few interviewees thought the current system had enough resources that simply needed to be used more efficiently, the majority felt that Houston/Harris County has major gaps in services, particularly in the areas of non-crisis mental health and substance use disorder services. Others cited a lack of safe, clean, affordable housing at all income levels; transportation, financial literacy and education; integrated health care and evidence-based behavioral health care; trauma-informed services; inpatient psychiatric beds, particularly for children and adolescents; specialty care services; health care services for the indigent; employment assistance; detoxification beds; and "step-down" care for those leaving acute-care facilities. Workforce shortages also were mentioned, including all types of mental health professionals, and non-clinical personnel such as peer support specialists/recovery coaches and Community Health Workers.

"Sometimes it's easier to say no [to data sharing] rather than figuring out how to say yes."
—Social Service Organization

As far as barriers to data sharing, again, the number one cited reason was misinterpretations of HIPAA and privacy laws such as 42 CFR Part 2, followed by difficulty in obtaining client consent. Many also mentioned having a lack of properly trained staff or staff's unwillingness to duplicate data entry. Others felt that the lack of uniformity among organizations' data collection processes (e.g. different EHRs, platforms, and data points being collected) posed the biggest barrier.

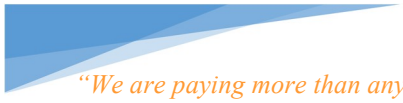
"Why do we let everyone fall off the cliff and try to pull them back on the mountain? Why don't we spend some money to keep them on the mountain? We use resources at the wrong point."

—Health Care Organization

Other policy changes that could facilitate organizational adoption of coordinated care included Medicaid expansion and additional guidance from the federal government regarding HIPAA. Social determinant screenings, whether done in the health care or other settings, was another common theme. Also mentioned were increased funding for behavioral health services, reimbursements for professional shortage area providers and increased funding for prevention and early intervention services.

The vast majority of interviewees agreed that in order to truly incentivize and pay for coordinated care, a global or bundled payment system must be implemented. Some also discussed the need to include incentives for positive performance. In the absence of that systemic change, they felt that at the least, collaborative care models should be reimbursed under the Fee-for-Service system.

Several interviewees remarked that Medicaid Managed Care Organizations (MCOs) have the flexibility to develop these models and hoped that they would do so. Others felt that hospitals had the funds to do more in this area and that marketing around corporate social responsibility could encourage them in those efforts.



"We are paying more than any country on earth for the worst outcomes, and Texas is among the highest on the list."

—Educational Institution

Focus Groups

In September and October of 2018, the Project Manager conducted five focus groups with mental health consumers and clients of primary care, behavioral health and social service organizations. They included:

- 18 Members of Prosumers International, who have lived experiences with mental health issues, including those who work as peer support specialists.
- 5 Clients of Memorial Assistance Ministries, who have participated in the Employment Certification program and received other services.
- 7 Patients at El Centro de Corazon, primarily Spanish-speaking, who received behavioral health and/or primary care services.
- 9 Residents of Santa Maria Hostel, all women, who lived on-site and either were participating in the program due to a court order or voluntarily.
- 11 Residents of Open Door Mission, all men, who lived on site and were at different stages of completing the 9-month recovery program.

Prosumers International

For the Prosumers International Group, a key to ensuring better coordination across medical, behavioral health and social services was a comprehensive resource database for referrals. They felt that many resource databases fall short because they do not include information on advocacy and support groups, which can be an important part of the recovery process. They also suggested that consumers be allowed to give feedback on whether or not services are available or accessible so the databases can be updated. They made several other suggestions, including having more detailed information available for each resource (besides phone numbers/websites), making one or more call-takers responsible for updating service information once a month and making the database available to the public. Members also suggested that a resource database include information on recreational and volunteer opportunities that can help people connect with others, citing a study that suggested loneliness and isolation "kill more people than obesity".

"There is some information we absolutely want shared…[but] There needs to be a level of respect that this is our information and we can share it with whoever we want to."

Another major issue discussed as a key—and yet also a potential stumbling block—to care coordination was data sharing. The members agreed that there could be benefits to data sharing, such as reducing the need to change address or contact information at multiple agencies.

However, stigma against mental health and substance use disorders continues to be widespread and persistent—even within the health care system. Many of the participants shared feelings of distrust toward health care providers and whether or not their very real physical health symptoms would be believed if the primary care physician knew he/she had a mental illness. If their data is being shared, the participants were adamant that there be informed consent about the exact data that would be shared.

The participants also discussed an ideal coordinated care system, which would communicate well with and understand consumers, as well as what affects them. They stressed that the system should not presume to know who a consumer is and what the consumer's capabilities are. Nor should it be overly punitive for behaviors that may be the byproduct of other issues, i.e. missing an appointment because one lacks transportation or just got evicted.

"I get penalized for the very barriers that make me need [health/behavioral health] services."

Memorial Assistance Ministries

The Clients at Memorial Assistance Ministries were looking for a system that helped them through every stage of their needs. Many related their stories about the multiple issues that accumulated in the wake of Hurricane Harvey. One discussed the severe stress of being unemployed for several months with dwindling savings and fears of losing housing. Another had to relocate due to Harvey, became unemployed and also faced transportation issues when car repair costs became too costly. These stories underscored the need for a person-centered system that can meet clients where they are and provide holistic services.

> *"[The ideal system is one where] you're not lost to the system, but the system is with you to follow-up with you at every step of the way."*

Clients also admitted to having a lack of knowledge and confusion regarding health care and possible coverage. Most of the participants were uninsured—including those who were employed—and were unaware of their coverage options. They described the health care system as one that "throws people off" because there are so many different aspects to it. They wanted a system that reduces duplication and protects privacy, but said that even before people get there, having a sort of "roadmap", handbook or even class for people who are moving between the social service and health care systems would be helpful.

Finally, the clients talked about the need for flexibility. When working people have a need for services, it is particularly helpful when organizations can provide those services at times that do not conflict with a client's job.

El Centro de Corazon

In the bilingual group at El Centro de Corazon, patients discussed what they think a coordinated care system means and how they would like such a system to look. Most of them believed that such a system would be one that is "on top of what the client's need are." The group felt that while integrated services is optimal, technology could allow for a coordinated care system even if all services were not delivered at the same site.

The group also felt that communication between the patients and providers, as well as among the providers themselves, is key to a coordinated care system. They said that a coordinated care system should be person-centered and make people feel welcome, important and comfortable. They also stressed that the system should be accommodating and flexible. Having hours that do not conflict with work and school schedules was very important to them.

This group viewed the sharing of their health care information among different providers as a plus. They believed it would make appointments more efficient, especially if they, for instance, could not remember the name of all the medications they currently were taking. It also would reduce their need to repeatedly present medical information to different providers.

As in other groups, they discussed how confusing the health care system is and a need for a step-by-step process to help them navigate the system. They also talked about current resources for finding available services in the community and the difficulty in locating up-to-date, comprehensive information from some of the publicly available resource databases. For these reasons, many of the patients relied heavily upon their case managers to help them coordinate all of the services they needed.

> *"We don't know about [what's available] ...can you help us, lead us in the right direction?"*

Santa Maria Hostel

For the women at Santa Maria Hostel, coordinated care meant a team coming together and working on the same page to implement everything necessary to meet their needs. As in previous groups, they also mentioned the benefit of being able to receive services in the same location. In the absence of having fully co-located services, the participants stressed the need for easily accessible services. For instance, they mentioned the benefit of having shuttle buses pick them up and drop them off wherever they need to go.

These clients also depend on their case managers for information about the services and benefits that are available to them, especially because there are so many programs with different eligibility requirements. They also appreciated that some providers assist them with obtaining health insurance. They suggested that all health, behavioral health and social service providers offer a universal intake form that determines whether clients are eligible for health insurance, housing, food stamps and other benefits.

They also recommended that these agencies hold resource fairs for clients to be able to obtain more information on available services in the community, as well as to be able to make appointments to receive those services.

> *"When I leave here, I have no place to go"*

Some expressed anxiety about what will happen when they transition back into the community, citing a lack of transportation, housing and access to medication. Overall, this group was looking for a coordinated system that could help them through every step of their journey.

Open Door Mission

The men at Open Door Mission felt that a coordinated care system is one that is organized and provides "whole care" with everybody—clients, doctors, therapists, case managers, etc.—working together to achieve an overall goal. The system would assist with all of a client's needs, including physical, emotional and social. The system also would follow-up with people after program completion with at least an occasional check-in to ensure that the client is still doing well.

> "Just helping to a certain point [isn't enough]…some people need more help."

Some of the services they felt were sometimes inaccessible included specialty medical care, housing, legal services and detoxification services. They mentioned that for some types of specialty care, the appointment is often set months after treatment is first sought. Medication, and the ability to pay for it, was another significant concern.

The men seemed to feel very comfortable with their medical information being shared among the various providers. They felt that the different doctors needed to be able to see what was going on with the client, and the information sharing would facilitate that by "keep[ing] everybody on the same page." They also mentioned that data sharing would make things easier and speed up the process by reducing the need to complete so much paperwork.

Yet again, the caseworkers emerged as the unsung heroes on the quest for a coordinated care system. As in other groups, the men stated that they rely heavily upon their case managers to connect them with needed services.

> *"It's hard for me to trust people. I trust my caseworker."*

CONSENSUS RECOMMENDATIONS

Based upon the input we received throughout each of the aforementioned information gathering stages, the full workgroup reviewed an initial set of 60 recommendations at the Mid-year retreat in October 2018. In the subsequent months, the recommendations were further scrutinized, revised and combined in the committees. At the final C^3 Initiative retreat in March 2019, the workgroup came to consensus on the 26 recommendations that are described below.

For a Local Agency:

- **Implement a comprehensive database of social service and health care resources that:**
  - **includes support groups, advocacy organizations, and recreational/volunteer opportunities;**

- **includes detailed program information on each agency (e.g., whether or not it is accepting new clients, forms of insurance accepted, eligibility criteria, etc.);**
- **is available for the public to access; and**
- **is routinely updated, including through feedback from end-users.**

The ability for both provider organizations and the public at-large to easily search for and locate needed community resources was a recurring theme throughout virtually all of the information gathering activities.

Although there are many different resource databases and lists that are available to the public, C^3 Initiative workgroup members, interviewees, survey and focus group participants stressed the need for information beyond health (including behavioral health) and social services, including details on program eligibility and accessibility. They also wanted an online, publicly accessible resource that is updated on a routine basis. Fortunately, the United Way of Greater Houston has started working to build a platform that will augment the current system in place and include many of these recommendations. Once unveiled, the new system will be accessible through multi-channels (i.e. chat and text) with the ability to track and close the loop on referrals made. The system also will allow the ability to update resources through an Application Programming Interface that allows the data to be accessed by outside organizations that serve niche communities for ease of updates. These changes are expected to provide a significant community benefit by ensuring more effective provider referrals and improved accessibility for the public.

For Local Health Care, Behavioral Health and Social Service Provider Organizations:

- **Incorporate into operations practices that include:**
  - **providing transportation for clients to and from their location to other providers;**
  - **holding resource fairs for consumers and including peer support specialists/recovery coaches as resources;**
  - **holding classes for patients and/or developing a handbook that explains how to navigate the health care system locally;**
  - **striving to hold flexible, non-traditional hours to meet the needs of working clients;**
  - **providing a quarterly training for case managers and other frontline staff regarding available community resources; and**
  - **educating staff and promoting inclusivity as it relates to programs and resources available based upon immigration status.**

There were a number of different recommendations aimed at local service providers that would facilitate patients' ability to access and benefit from their services. Because lack of transportation was cited as one of the top barriers to coordinated care, organizations should consider formation of a transportation network that provides rides for patients between

provider organizations. They also should engage in informational activities that include resource fairs that inform consumers about other services and resources available in the community and classes that educate them on how to navigate the health care system. And because many clients—particularly those who are lower-income or hourly workers—do not have the flexibility to miss work, local organizations must also seek to provide more flexible hours that extend beyond a typical workday. Finally, local provider organizations should work to ensure that their employees receive pertinent education and trainings. Because case managers and other frontline staff who play critical roles in helping refer consumers to services may change on a frequent basis, it was recommended that a training be developed and held quarterly that will allow staff who are new to their roles to learn about available community resources for referrals. Ensuring that staff is trained not only in cultural competence but also in some of the nuances related to serving those who are noncitizens (i.e. being able to educate clients on the consequences of receiving certain services due to potential new federal rules) is also important.

- **Integrate primary care, behavioral health and social services and, to the extent possible, make those services available on-site.**

People with mental illness are five times more likely to have a co-occurring physical health condition than those in the general population.[vi]

In addition, the systems for treating consumers with co-occurring serious mental illness and substance use disorders are highly-fragmented, "contributing to poor health outcomes and elevated levels of unmet treatment needs."[vii] However, studies have repeatedly demonstrated that models that integrate primary and behavioral health care can improve patients' mental health, substance use disorder and health outcomes.[viii,ix,x] And as previously explained, social determinants such as employment, housing and transportation have a far greater impact upon patient health than clinical care.[xi] As demonstrated through the C^3 focus groups, clients are seeking organizations that have a full range of medical, behavioral health and social services that address their diverse needs. Agencies that seek to provide clients with seamless access to these services can help improve their overall health, quality of life, and satisfaction.

- **Develop and adopt a universal client consent form for purposes of data sharing across agencies.**

Even though there are instances where laws "do not require or offer the opportunity for individual consent,"[xii] for many consumers, consent is the cornerstone of data sharing. Many of the potential objections to data sharing begin to fade when it becomes clear that the patient has given consent to sharing his/her data. In order to facilitate this process, local service providers should work together to develop a universal form that ***all*** organizations can use that will inform the client of the uses of the data and allow for a more seamless transfer of consent from one organization to another.

- **Whether through formal screening or another appropriate method, assess both the social-environmental and health (including behavioral health) needs of patients/consumers/clients.**

  People with mental illness are more likely to have a co-occurring physical illness than those in the general population[xiii], those with substance use disorders "have a range of health conditions that are directly related to those disorders," and people with chronic health conditions such as diabetes and cancer are at a higher risk for depression.[xiv] It also bears repeating that socio-economic factors influence health at a greater rate than clinical care. "Screening for social determinants of health can help to identify patients who may benefit from greater support in one or more areas, thus promoting whole-person care for the entire population."[xv] Some local primary care providers have begun administering social determinant assessment tools and screening for food insecurity, which are positive steps and should be broadened. Both health and socio-economic assessments should become more standard practice among medical, behavioral health and social service providers with the goal of incorporating this knowledge into patient advice and/or referring them to organizations and resources that can assist them with addressing the identified needs.

For the United States Congress:

- **Provide funding and/or financial incentives for behavioral health providers to implement Electronic Health Records.**

  A key component of care coordination is the ability to share client information among providers. While Health Information Technology can facilitate this process, it is complicated by the fact that "adoption of EHRs in behavioral health settings lags behind adoption in other areas of health care."[xvi] Part of this can be attributed to many behavioral health clinicians' concerns about patient privacy and confidentiality issues related to HIPAA and 42 CFR Part 2. However, another significant issue is the fact that behavioral health providers were excluded from the billions of dollars of financial incentives doled out to health care providers for meaningful use of EHRs. In order to address this discrepancy and level the playing field for mental health and substance use disorder service providers, the United States Congress should provide funding to behavioral health providers for adoption of EHRs in a manner similar to what was done for other health care providers.

- **Pass legislation requiring the provision of high-quality, affordable health care coverage to all U.S. residents.**

  The Affordable Care Act (ACA) extended health care coverage to millions of Americans. However, due in large part to recent actions taken against the law, in 2017 the number of uninsured in the U.S. increased for the first time since the ACA's implementation.[xvii] In

addition, 45% of the uninsured stated that they were uninsured because they could not afford health coverage.[xviii] Others who have health insurance sometimes find that it does not provide the full range of coverage they were expecting and end up with exorbitant out-of-pocket costs. In order to help ensure that Americans are able to access the health care services they need when they need them, the United State Congress should pass legislation making high-quality, affordable health care coverage available to all.

For the United States Department of Health and Human Services:

- **Develop and issue a Health Insurance Portability and Accountability Act-compliant data sharing Memorandum of Understanding template to assist organizations seeking to share client data.**

  As previously mentioned, a lack of understanding and misinterpretations of HIPAA have hampered care coordination and information sharing efforts among organizations. Many providers believe that HIPAA has stringent prohibitions against sharing client data and are fearful of violating the law and being subject to stiff penalties. Of course, HIPAA regulations actually "were intended to support information sharing"[xix] while ensuring that sensitive patient data would be protected. The U.S. Department of Health & Human Services' (HHS') Office for Civil Rights and Office of the National Coordinator for Health IT have worked to dispel misinformation by developing HIPAA fact sheets specifying data that can be shared. The Department also has provided model privacy notices for providers. However, in order to better facilitate care coordination, HHS also should develop templates of data sharing Memorandums of Understanding that can be used by organizations seeking to coordinate care among one another. This would help reduce the barriers that may be erected by legal over-interpretations of HIPAA that are common in many organizations.

For Appropriate Federal and State Regulatory Agencies:

- **Monitor and ensure compliance with the Mental Health Parity and Addiction Equity Act.**

  The Mental Health Parity and Addiction Equity Act (MHPAEA) and subsequent expansions required health plans to provide mental health and substance use disorder benefits at the same level as medical and surgical benefits.

  However, many providers and consumers continue to run into barriers, such as health plan medical necessity and preauthorization requirements, that limit the provision of behavioral health services. One way to ensure that insurance companies are not discriminating is to improve enforcement activities. The 85th Texas Legislature passed HB 10, which gives the Texas Department of Insurance the ability to enforce parity provisions in the health plans it regulates.[xx] TDI needs to be diligent in monitoring and enforcing these regulations. At the federal level, however, the Department of Labor, which oversees large employer-sponsored group health plans, "cannot directly enforce MHPAEA with insurance

companies, even when there is evidence of a parity violation."[xxi] The U.S. Congress should pass legislation that strengthens DOL's ability to enforce this important consumer law.

For the Texas Legislature:

- **Expand Medicaid as set forth under the Affordable Care Act or provide alternative high-quality, affordable health coverage options.**

  Just as the rest of the nation, Texas has seen its uninsured rate increase recently. In fact, Texas remains home to the most uninsured Americans, with 1 in 5 uninsured children living in this state and an overall uninsured rate of 19%.[xxii,xxiii] Texans have made it clear that they want state lawmakers to make increasing access to health coverage a priority, with almost 2/3 supporting the expansion of Medicaid.[xxiv] In spite of this, the 86th Legislature again adjourned without making progress on any of the dozen plus bills that would have addressed this issue. If state leaders are going to remain steadfast in opposition to Medicaid expansion, they should pursue alternatives—including potential federal waivers—that will allow it to make use of federal matching funds to ensure coverage to the state's most vulnerable populations.

- **Require training and other provisions to ensure that state-funded health care services are trauma-informed.**

  Adverse Childhood Experiences (ACEs) are traumatic experiences—such as physical, emotional and sexual abuse and neglect—that occur prior to age 18. Just over 60% of adults report experiencing an ACE, while almost one-quarter report experiencing 3 or more ACEs.[xxv] ACEs can have long-lasting negative impacts on those who experience them and "have been linked to risky health behaviors, chronic health conditions, low life potential, and early death."[xxvi] Trauma-informed care has been described as a "promising practice that may facilitate healing and help prevent the consequences of exposure to trauma."[xxvii] The prevalence of ACEs among the population, as well as their potential lasting effects, makes it necessary to ensure that those who experience them have access to services that help to mitigate their impact. That is why the Texas Legislature should require that all state-funded health care services be trauma-informed.

- **Increase funding to expand the number of psychiatric residency positions.**

  The behavioral health workforce shortage is a problem affecting the entire United States, though it hits Texas particularly hard.

  78% of Texas counties have been designated full or partial Mental Health Professional Shortage Areas.[xxviii] More than 2/3 of Texas Counties lack ***any*** psychiatrists, while another 9% have only one.[xxix] While the Texas Legislature has passed legislation making it easier for out-of-state psychiatrists to transfer to and practice in Texas, it must also increase its

investment in psychiatric residency programs to expand the number of psychiatrists trained in the state.

- **Increase funding to expand the number of available inpatient psychiatric and detoxification beds.**

  Among all states and the District of Columbia, Texas is in the bottom quintile of per capita psychiatric inpatient beds with 23.5 beds per 100,000.[xxx] Throughout the C^3 Initiative process, providers also frequently mentioned a lack of detoxification beds. While the 85th Texas Legislature appropriated millions of dollars to repair state hospital infrastructure and add new state hospital and community beds—including 240 beds as part of the new UTHealth Continuum of Care Campus at the Harris County Psychiatric Center in Houston—these investments must continue. The Legislature also must make similar, substantial investments in detoxification beds in order to help combat the opioid crisis.

- **Fund the provision of behavioral health counseling services on all public school campuses.**

  About half of all lifetime cases of mental illness begin by age 14.[xxxi]

  And "[w]ithout treatment, children with mental health issues are at increased risk of school failure, contact with the criminal justice system, dependence on social services, and even suicide."[xxxii] By the very nature of the significant amount of time that children spend on their campuses, schools are becoming an important frontline in recognizing and referring students with mental health and substance use issues to appropriate services. While the 86th Texas Legislature has passed legislation that will make behavioral health services more accessible to public students, state leaders must make a firm commitment to providing the funds necessary to ensure that behavioral health services are available on ***all*** public school campuses.

For the Texas Legislature and Local Government:

- **Increase funding for services that promote prevention and early intervention related to health, behavioral health and socio-economic issues.**

  Effective prevention activities are critical to maintaining public health and have a significant return on investment. For instance, targeted disease prevention efforts would have an estimated return of $5.60 for every $1 invested over a five-year period.[xxxiii] Effective school-based substance abuse prevention programs could yield a return of $18 for every $1 spent.[xxxiv] The same can be said of social determinant issues such as housing instability, food insecurity and unemployment—preventing individuals from developing those issues can reduce the societal costs related to the potential effect of those problems. In short, prevention and early intervention services are a far more cost-effective investment than the would-be costs of the health care, criminal justice and other systems. Thus, the Legislature should significantly invest in prevention and early intervention health,

behavioral health and social services in order to help improve both individual and community outcomes.

- **Provide funding and other incentives for health care, behavioral health and social service agencies to coordinate care.**

  Throughout the C^3 Initiative planning process, lack of funding was repeatedly identified as a serious organizational barrier to care coordination. There are many state agencies that currently provide funding to community-based organizations to provide health, mental health, substance use disorder, and social services to clients, including the Health and Human Services Commission, Department of State Health Services, Department of Family and Protective Services, and Department of Housing and Community Affairs. While these agencies meet and communicate on a periodic basis, the funding streams that flow from them to community-based organizations remain stratified. All state agencies responsible for health care, behavioral health and social service funding should work together to determine how their monies can be used in order to incentivize care coordination among local organizations.

- **Increase funding for community-based mental health and substance use disorder services.**

  An estimated 3.3 million Texas adults have a mental illness, about 1 in 10 children have a Serious Emotional Disturbance, and almost 1.4 million Texans 12 and older have a substance use disorder.[xxxii,xxxii]

  While Texas historically has had among the lowest per capita funding rate for mental health and substance use disorder services, the Texas Legislature has made great strides in the last several legislative sessions in order to ensure adequate funding for the millions of Texas children and adults who suffer from these illnesses. The Legislature should continue to invest significant funding in building out the full continuum of community-based behavioral health services, ranging from prevention and early intervention services to outpatient and residential services.

For Local Governments:

- **Increase funding for public health services.**

  Public health services have been at the core of many achievements such as safer foods, eradicating and minimizing diseases, and improving water quality, thereby also preventing premature death and disability. However, "[d]espite widespread rhetorical endorsement of prevention, public health programs have received less attention and far less funding than personal medical service."[xxxvii] In fact, estimates show that public health is underfunded by as much as $20 billion nationally.[xxxviii] This chronic underfunding "has had detrimental effects on population health."[xxxix] Public health gets to the root causes of poor health and, by effectively addressing them, has the potential to reduce overall health care spending.

For this reason, local government entities should increase their investment in these services that are vital to a healthy community.

For Health Care Payers:

- **Prioritize the widespread implementation of a global payment reimbursement model that is value-, outcomes-and risk-based.**

While the Centers for Medicare and Medicaid Services has led the way in promoting value-based payment models, Texas state officials also have taken up the challenge.

In 2018 in its Medicaid and CHIP Managed Care Manual, the Health and Human Services Commission set forth a requirement that MCOs tie at least 25% of their payments to Alternative Payment Methods (APMs), such as global and bundled payments, with at least 10% of them being risk-based. It further required MCOs to increase the percentage annually until half of their payments used APMs and 25% were risk-based.[xl] Yet the move toward value-based models need not be limited to the state Medicaid program. All health care payers should be seeking to implement risk- and value-based alternative payment models that provide global payments for services ranging from episodes of care (e.g. a "bundled" pregnancy and delivery services) to fully integrated services that cover an individual's total health, behavioral health and socio-economic needs.

- **Reimburse for navigation and coordinated care/treatment planning services under the current Fee-for-Service model.**

Until the move to a global payment model is complete, providers will continue operating under the current Fee-for-Service model but must be able to be reimbursed for nontraditional activities that improve patient care. In order to effectively coordinate care, organizations need to be able to communicate with one another and collaborate regarding treatment plans. They also need to be able to assist their clients in navigating through and accessing referrals. While these can be time-consuming activities, they can contribute to better outcomes, which is why it is important that providers be reimbursed for them. Care coordination billing codes currently are available and in-use within the Medicare program, but similar codes should be developed for use by both Medicaid and non-Medicaid providers.

- **Reimburse for prevention-based activities—such as screenings—as well as the services that address socio-economic factors under the current Fee-for-Service model.**

As previously mentioned, prevention activities—including those aimed at addressing socio-economic factors—are important for improving both individual and population health. "Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual's ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization."[xli] In order to guard against these potential negative

outcomes, many health care providers have begun assessing patients for risk factors related to food insecurity, lack of housing and other social determinants and either providing them with needed services or making appropriate referrals. Currently, there are some billing codes available that allow providers to document patients' socio-economic needs, but payers are not routinely reimbursing for them. Fortunately, some payers are taking positive steps to address social determinants, such as Kaiser Permanente, which is investing $200 million to tackle housing instability and homelessness.[xlii] However, payers must also align their reimbursement structures to allow the providers who are identifying these issues to be reimbursed for providing or connecting the clients with the services to address them.

- **Reimburse for services provided by non-clinical staff, such as peer support specialists, Community Health Workers and case managers.**

There are a number of valuable non-clinical services that are not routinely reimbursed by health care payers.

For instance, peer support services have been shown to be "effective in engaging people into care, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with co-occurring substance use disorders."[*xliii*] Although they are now a reimbursable benefit under the Texas Medicaid program, their services are not reimbursable by many health plans. Neither are the valuable services provided by Community Health Workers, which "can improve people's health, lower health care costs, and address health disparities."[xliv] Due to the many benefits that these specialists can provide to consumers, Texas health care payers should provide reimbursement for the services they provide.

- **Work to expedite credentialing for providers to serve on insurance panels.**

Throughout the C^3 Initiative data gathering process, many providers cited treatment barriers resulting from delays in the credentialing process. In order for a health care provider to be able to bill for services provided to a patient, a payer must "credential" or verify the provider's education, work, compliance, etc. history in order for that provider to be admitted to the network and serve on the insurance panel for reimbursement. Insurance panels may have a credentialing process with a predicted completion time of 90 – 180 days, but many times this process can take far longer to finalize. That means that if a practice is at capacity, hiring a new provider will not immediately open the schedule for more appointments because that provider cannot see and bill for clients until he/she is credentialed. This is particularly problematic when it is a high-demand provider (e.g. a bilingual provider). While this is not uniform across insurance companies, those with long delays in credentialing create unnecessary barriers to treatment. Health care payers should review their current credentialing practices and work with providers to determine ways to make the process faster and more efficient.

- **Ensure full integration of physical and behavioral health services.**

  Effective February 8, 2019, the Health and Human Services Commission placed new requirements on MCOs to integrate physical and behavioral health service administration, including streamlining credentialing procedures and operating a single provider portal for physical and behavioral health providers to submit claims and claims appeals, prior authorization requests," etc.[xlv] While the requirement did not prohibit the "carving out" of behavioral health services to third party Behavioral Health Organizations, "the experience with carve-out payment arrangements strongly suggests that they impede the delivery of integrated care."[xlvi] Maintaining carve-outs reinforces the division between physical and behavioral health services and can place unnecessary additional burdens on providers that deliver behavioral health services, particularly those that have integrated operations. It is time for Texas health care payers to end the practice of carving out behavioral health services.

For Medical and Clinical Schools:

- **Strengthen social determinant of health curriculum and education and ensure that all students receive this education, including through continuing education opportunities.**

  The Liaison Committee on Medical Education, which is the accrediting body for the Association of American Medical Colleges, currently requires that education regarding social determinants of health is included in medical school curriculum.

  Although this demonstrates progress, the implementation and depth of the education varies from institution to institution due to the flexibility in the current requirements. Therefore, SDOH curriculum and experiences should be strengthened to ensure students graduate with: knowledge of the relationship between SDOH and health; an understanding of the social-environmental conditions that their patients face; knowledge of the various treatments that effectively address these issues; culturally competent methods of communication; and an understanding of how addressing SDOH may affect their reimbursements (e.g. value-based payments, etc.). This curriculum should be incorporated across areas to allow for maximum exposure rather than a single class or specialized track. Providing inter-professional education/training opportunities between medical, nursing, psychology, graduate social work and other graduate students also would be beneficial. Finally, institutions of education can leverage relationships with local partner organizations to ensure continuing education opportunities in this area.

For Philanthropic Organizations:

- **Prioritize direct services grant funding for agencies that collaborate to provide patients with coordinated care.**

  Foundations and other philanthropic organizations can use the power of the purse in order to shape the programs and activities of the organizations they fund. Over the past two

decades, funders have helped to shift organizations' focus from volume and quantity to outcomes and quality. The same can happen regarding coordinated and collaborative care. When multiple organizations are vying for a limited amount of funding, foundations can help to move them in the direction of coordination by including those requirements in their funding applications. Funding for organizations that actively work to meet client needs through collaboration with others should be prioritized over those that continue operating in silos.

PILOT PROJECT DEVELOPMENT & OVERVIEW

While the information gathered throughout the C^3 Initiative planning process was used to inform pilot project development, the work of the committees was most crucial in this area. More details regarding their responsibilities and deliverables are outlined in further detail below.

Continuum Development Committee

One of the key responsibilities of this committee was to determine the target population and target communities for the pilot project. Very early in the process, the members agreed that the target population should include consumers with at least one mental health diagnosis. Due to the high co-occurrence of mental illness and substance use disorders, the members agreed that people with substance use disorder would be served even if that was not a specific eligibility requirement. The group also felt that, since the aim of this project is to coordinate care across multiple systems, that the participants should have at least one social service need. Specific physical illnesses were not included in the eligibility criteria because everyone has a need for primary care services, and patients ideally will be served further upstream before developing a medical issue.

Regarding income, the committee settled on 200% of the Federal Poverty Level and below in order to capture clients with the greatest financial need and because that aligned with the financial criteria for many of the participating organizations. Discussions regarding limiting the pilot project to a specific age group stalled, so the committee agreed that children who live with their families and adults with or without their families would be served.

For the target communities, the committee felt that in order for the pilot project to be successful, the communities had to have available resources to serve the target population. While they decided not to target resource deserts, they also didn't want to target areas where clients already could access a number of resources with or without coordination. Ultimately the committee agreed to target "moderate" resourced communities.

In alignment with the target population, the committee also focused on lower-income communities with high health (including behavioral health) and social service needs. Finally, in order to avoid service duplication, the committee opted not to target communities where similar coordination efforts already are underway.

Through overlaying data provided by Welnity.com, Texas Children's Hospital, and HealthLandscape, the committee identified seven potential communities. After engaging with providers and clients in some of the areas, the committee made a recommendation to target Spring Branch/Northwest Houston and Fifth Ward/Northeast Houston for the pilot project.

The committee's last major task was to determine the mix of services that would be needed in the pilot project in order to ensure success. While other services may be included, below are the top services the committee felt should be available to pilot project participants, whether through the participating pilot organizations or referrals:

General Medical:	***Behavioral Health:***	***Social Services:***
Outpatient Primary Care	Psychiatric/Medication Management	Transportation
Pharmacy Services	Individual & Family Counseling	Employment Assistance
Specialty Health Care	Inpatient Mental Health	Financial/Income Assistance
Home Health Care	Home & Community Based Services	Housing Assistance
Emergency Health Care	Intensive Outpatient Addiction Services	Benefits/Insurance Eligibility
Urgent Care	Crisis Residential Psychiatric Services	Childcare
Early Childhood Intervention	Peer Support Services	Food

Case Management Integration Committee

This committee developed the case management and coordination plan for the pilot project. Because most of the members were case managers or otherwise involved with coordinating care for clients, they began by discussing the barriers they faced in those areas on a daily basis. These included: different intake forms for different services; lack of service capacity information and real-time data for service providers; lack of a unified care plan for patients who are receiving services from multiple organizations; and office-bound case managers' limited access/communication with clients to ensure service continuity after referrals.

The committee also reviewed various evidence- and best practice-based models used in social determinant care coordination, including the Pathways Community HUB Model, Health Park Model and Guided Care® Model. The Pathways Community HUB Model, which uses Community Health Workers to identify and connect high-risk individuals with up to 20 pathways addressing medical, behavioral health, and socio-economic issues, presented the model most closely aligned with the goals of the C^3 Initiative. In addition, the model had just been adopted by another local pilot project—Healthy Women Houston.

Based upon the barriers presented and the Pathways Community HUB Model, the committee designed a plan that incorporated the following:

- ***Implementing a universal intake form*** to ensure there is "no wrong door" through which a participant can enter into the pilot program.

- ***Entering participant information into a data sharing and care coordination platform*** that includes:
    - A built-in database of resources to which case managers can refer participants and is routinely updated;
    - Notifications of when a participant accesses referrals, as well as what services the participant receives;
    - A strong reporting capability that includes participant receipt of services and any no-shows to spur case manager follow-up.
- ***Initiating the development of a care plan*** (negotiated with the participant) at the point of initial intake that allows:
    - Care plan updates from care team members, including all organizations involved in the participant's care;
    - The sending of alerts to all members of the care team when the care plan is updated;
    - The inclusion of "case notes" that are goals that have not yet been negotiated with the participant.
- ***Funding a care coordinator position*** that will be responsible for working with all participating pilot project agencies and helping participants to access needed services.

The committee also worked with the Continuum Development Committee to recommend a combined version of the Healthy Women Houston intake form and PRAPARE assessment tool for intake, and to use the Daily Living Activities (DLA)—20 to assess participants' baseline needs and track their progress.

Data Sharing & Analytics Committee

For this committee, the vast majority of its attention focused on recommending the platform that would be used for the organizations participating in the pilot project. Working with each of the other committees, it gathered information regarding the desired features of the pilot project. The key features included (but are not limited to) the:

- Ability to import data from partner organization databases into the platform through data transmission or flat file transfer;
- Integrating into the C^3 platform the use of both standardized and customized assessment tools;
- Communicating in real-time with other care team members, such as through instant messaging;
- Running reports detailing participants' receipt of services, missed appointments, etc.; and
- Accessing a database of resources that is regularly updated to which participants can be referred for services.

The committee then worked to develop and issue a Request for Information to about 20 vendors to review their potential capabilities. Of those, nine submitted responses. After the Evaluation Subcommittee reviewed the responses, they selected the five strongest proposals and invited those

vendors to demonstrate their platforms to the group. After the demos, the committee decided it needed further information—such as pricing and scope—so it developed and issued a formal Request for Proposal, receiving six responses. The committee selected three of those vendors and invited them back for a final demo. One week prior to the demos, the vendors were sent a demo framework that included scenarios the committee expected to encounter in the pilot project. Vendors were asked to give a brief overview of their platforms and to demonstrate how their platform would address each of those scenarios.

Upon completing the demos, the vendors were evaluated upon general features like security, as well as their ability to complete each of the scenarios. ClientTrack, a product of Eccovia Solutions, ultimately was selected due to its robust features, strong security, flexibility, smart workflow, and ability to integrate with other systems, like 211.

Pilot Project Implementation

Coalescing the work of the committees, a strong framework for pilot project implementation was developed. The C^3 pilot will target adults and children who live with their families and have a diagnosable mental illness, a need for at least one social service and have a household income at or below 200% of the Federal Poverty Level who live in Spring Branch/Northwest Houston or Fifth Ward/Northeast Houston.

The pilot project will include several key elements. The first is a strong network of primary care, mental health, substance use disorder and social service providers. Organizations that are expected to be a part of the pilot and provide services in some capacity to participants in one or both of the target communities are:

- Catholic Charities
- Houston Food Bank
- Main Street Ministries
- Memorial Assistance Ministries
- NAMI Greater Houston
- Santa Maria Hostel
- Spring Branch Community Health Center
- Spring Branch Family Development Center
- The Council on Recovery
- The Harris Center for Mental Health & IDD
- The Women's Home
- Vecino Health Centers
- Wesley Community Center

Another key element will be the electronic platform—ClientTrack—which all of the pilot organizations will use, either through direct data entry or a system integration that reduces the need

for organizations to enter data into multiple databases. The platform will ensure that the pilot organizations are connected and able to share participant data and develop joint care plans; have real-time communication between members of the care team; receive notifications of when a client accesses referrals and what services the client received; and have access to a regularly updated database of resources to which participants can be referred.

The final critical element of the pilot project will be the care coordinators who, based upon the Pathways Community HUB Model, will work across all of the pilot organizations to remove barriers that prevent participants from accessing needed services. They will help coordinate services for participants that are not provided by one or more of the pilot organizations, ensure that participants attend appointments and be available to the participant in the community, as necessary.

Using the "No Wrong Door" approach, participants will be able to enter the program through any of the pilot organizations, as well as through the care coordinators. In accordance with the Pathways Community HUB Model, each participant will be assigned one care coordinator.

In order to ensure privacy, participants will only be accepted into the pilot if they consent to share their health (including behavioral health) and social service data with other pilot organizations. All participant data will be entered into the ClientTrack platform.

In general, the organization that initiates the participant's entry into the program will assess the participant using the DLA-20, and the results will be included in the platform. The DLA-20 will be administered to the participant on a periodic basis to determine progress.

The initiating organization also will begin development of the care plan, which will include negotiated participant goals and/or action steps. The care plan will be a living, breathing document and allow each member of the care team who provides services to the client to update it, as well as track who else made updates. Additional pilot project implementation details and workflows currently are being worked out among the pilot organizations and with the platform vendor.

The pilot project is expected to launch in late Summer/early Fall 2019 and serve approximately 300 individuals over the 2-year period.

Among other things, the expectation is that the C^3 pilot will:

- Improve service provider knowledge about the many different services that their patients are receiving in other systems;

- Improve service provider knowledge about the staff members who are working with their clients and offer the ability for them to communicate directly;

- Improve care coordination and reduce service duplication as service providers jointly determine who should be responsible for providing each service to a consumer;

- Enable service providers to collect and access important social determinant information on clients;

- Facilitate earlier intervention and reduce patients' likelihood of experiencing a crisis or emergency need as service providers become more immediately aware of when patients miss appointment or fail to access referrals; and

- Improve overall consumer health and quality of life through the development of care plans that take into consideration social determinant information, as well as all of the other services that a client is receiving from other service providers.

CONCLUSION

The year-long process of convening dozens of organizations, engaging with hundreds of individuals and developing consensus around policy/system recommendations and a pilot project framework has been a challenging yet gratifying experience. The commitment of the 60+ organizations that remained at the table throughout this process is a testament to the greater Houston provider community's desire to work collaboratively and set aside silos in order to improve their clients' overall health and wellbeing.

NBHP is pleased to have led this initiative and will continue working with its partners over the next several years to implement these recommendations, as well as ensure the success and expansion of the pilot project. We hope that each organization that participated—and even those that did not—will seek to work together as long as it takes until greater Houston implements a system-wide, person-centered continuum of care that integrates medical, behavioral health and social services while addressing the social determinants of health.

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APPENDICES

A. List of C^3 Steering Committee Members

B. List of C^3 Participating Organizations

C. List of C^3 Community Survey Participants

D. List of C^3 Confidential Interviewees

APPENDIX A—C^3 Initiative Steering Committee

Anna Coffey, CEO, The Women's Home

Lisa Dahm, Assistant County Attorney and Privacy Officer, Office of Harris County Attorney Vince Ryan

Angelina Esparza, Chief Program Officer, Houston Department of Health

Suzanne Jarvis, Program Manager, Houston Recovery Center

Tanweer Kaleemullah, Harris County Public Health

Leonard Kincaid, Executive Director, Houston Recovery Center

Jeannette Kolarik, Program Director, Harris County Felony Mental Health Court

Alicia Kowalchuk, MD, Associate Professor, Baylor College of Medicine

Charlzetta McMurray-Horton, Administrative Director, Utilization Management, Harris Health System

Keena Pace, The Harris Center for Mental Health and IDD

Ann Robison, Executive Director, The Montrose Center

Nadine Scamp, CEO, Santa Maria Hostel

Eva Thibaudeau, Vice-President of Programs Coalition for the Homeless

Kavon Young, MD, Medical Director, El Centro de Corazon

APPENDIX B—C^3 Initiative Workgroup

Access Health
Avenue 360
BakerRipley
Baylor College of Medicine
Career and Recovery Resources, Inc.
Catholic Charities
Cenikor Foundation
Children's Defense Fund
Christ Clinic
City of Houston Mayor's Office
Community Health Choice
The Council on Recovery
DePelchin Children's Center
El Centro de Corazon
Family Houston
First3Years
Gulf Coast Community Services Association
The Harris Center for Mental Health & IDD
Harris County Attorney's Office
Harris County Criminal Courts at Law
Harris County Department of Education
Harris County Felony Mental Health Court
Harris County Judge's Office
Harris County Juvenile Probation Department
Harris County Precinct One
Harris County Public Health
Harris Health System
Healthcare for the Homeless - Houston
HGI Counseling Center
Houston Coalition for the Homeless
Houston Department of Health
Houston Food Bank
Houston Methodist
Houston Recovery Center
January Advisors
Jewish Family Service
Legacy Community Health
Main Street Ministries
Meadows Mental Health Policy Institute
Memorial Assistance Ministries
Memorial Hermann
Menninger Clinic
Mental Health America of Greater Houston
NAMI Houston
Northwest Assistance Ministries
Open Door Mission
Prosumers International
Salvation Army
San Jose Clinic
Santa Maria Hostel
SEARCH Homeless Services
Spring Branch Community Health Center
Spring Branch Family Development Center
Star of Hope Mission
Texas Children's Hospital
The Beacon
The Montrose Center
The Women's Home
United Way of Greater Houston
UT Health
Vecino Health Centers
West Houston Assistance Ministries
Working Partner

APPENDIX C—C^3 Initiative Community Survey Participants

AAMA
AARP
Access Health
Angela House
Archway Academy
Avenue 360 Health & Wellness
BakerRipley
Baylor College of Medicine
Beacon Law
Career and Recovery Resources Inc.
Catholic Charities
Cenikor
Christ Clinic
City of Houston
Coalition for the Homeless
Community Health Choice
The Council on Recovery
Covenant House Texas
Cy Fair Community Health Center
DePelchin Children's Center
El Centro de Corazon
Family Houston
Felony Mental Health Court
First3Years
Fort Bend Regional Council on Substance Abuse
Gulf Coast Community Services
The Harris Center for Mental Health and IDD
Harris County Attorney's Office
Harris County Community Services Department
Harris County Department of Education
Harris County Juvenile Probation Department
Harris County Public Health
Harris County Sheriff's Department
Harris Health System
Healthcare for the Homeless - Houston
HGI Counseling
Hope and Healing Center & Institute
Houston Food Bank
Houston Recovery Center
Innova Pain Center
IntraCare Behavioral Health
Jewish Family Service
Kelsey Seybold Clinic
Kingwood Pines Hospital
Krist Samaritan Counseling Center
Legacy Community Health
Lifeway International/Cates Academy
Magnificat House
Main Street Ministries
Memorial Assistance Ministries
Memorial Hermann
Mental Health America of Greater Houston
Methodist Hospital
Open Door Mission
NAMI Greater Houston
Northwest Assistance Ministries
NSH
Prosumers International
Public Health Pediatrics
Salvation Army
Santa Maria Hostel
Spring Branch Community Health Center
Star of Hope Mission
Teen and Family Service
Texas Children's Health Plan
Texas Children's Hospital
Texas Network of Youth Services
The Alliance
The Beacon
The Housing Corporation
The Montrose Center
The Women's Home
UnitedHealthcare Community Plan
United Way of Greater Houston
UTHealth
West Houston Assistance Ministries

APPENDIX D—C^3 Initiative Interviewees

Anna Babin, President & CEO, United Way of Greater Houston
Bill Bailey, President and CEO, Cenikor Foundation
Wendy Baimbridge, Assistant Chief, Houston Police Department
Marilyn Brown, President and CEO, Coalition for the Homeless*
Leslie Bourne, President & CEO, Covenant House
Dave Buck, MD, Associate Dean of Community Health, University of Houston College of Medicine
Heidi Bunyan, Interim President & CEO, San Jose Clinic*
Katy Caldwell, President & CEO, Legacy Community Health
Alan Dettlaff, Dean, University of Houston School of Social Work
Ken Janda, President & CEO, Community Health Choice*
Andrea Caracostis, CEO, HOPE Clinic
Andy Keller, CEO, The Meadows Mental Health Policy Institute
Joel Levine, Executive Director, Harris County Protective Services for Children and Adults
Elena Marks, President & CEO, Episcopal Health Foundation
George Masi, President & CEO, Harris Health System
Carol Paret, CEO, Memorial Hermann Community Benefit Corporation
David Persse, MD, Medical Director, Houston EMS, Houston Fire Department
Henry Rush, President & CEO, Star of Hope Mission
Terry Scovill, CEO Healthcare Operations, IntraCare Behavioral Health
Umair Shah, MD, Executive Director, Harris County Public Health
Mel Taylor, President & CEO, The Council on Recovery
Amanda Timm, Executive Director, Houston LISC
Charly Weldon, President & CEO, Family Houston
Stephen Williams, Director, Houston Health Department
Wayne Young, CEO, The Harris Center for Mental Health and IDD
Sharon Zachary, CEO, Alliance of Community Assistance Ministries

***** *Title at the time of interview*