alameda county care connect

A Whole Person Care Pilot

Alameda County's Whole Person Care Pilot: Our Top Accomplishments

- Care Connect **invested in and mobilized safety net organizations across the county** to commit to **building and strengthening connections between systems** (housing, medical, behavioral health, legal, etc.), participating in **multi-sector trainings and capacity development**, and **collaboratively problem-solving system challenges** in order to improve care coordination between organizations and **promote better health and social outcomes for our communities**.
- Care Connect **significantly transformed the county's data integration efforts** though the development of a **Social Health Information Exchange (SHIE), which contains over 600,000 consumer records**, and **launch of a Community Health Record (CHR)**, a front-facing application connecting data from **14 sources** and providers from over **100 programs from 25 organizations** to **enhance communication and care coordination across sectors.**
- Building on the strengthened cross-sector partnerships and rapidly expanding data integration efforts, Care Connect organized a **rapid response to the COVID-19 crisis, preventing spread of infection and COVID-19 related deaths in high-risk populations, and housed over 2,000 guests** in isolation and quarantine hotels, where consumers were also **connected to much needed resources, such as healthcare, SUD treatment, behavioral health, and housing services.**

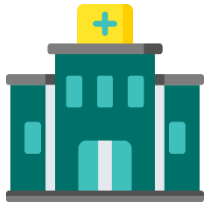
Contra Costa Key Accomplishments

CONTRA COSTA HEALTH SERVICES

- **Data-Driven** Risk Model for **Proactive identification** of patients (no referrals)
- **Single Electronic Care Plan** integrating health and social services visible to all care team members
- **Extensive Research and Evaluation – found that the longer that patients are enrolled in the program, the less likely they are to turn to the emergency room for care** and the less often they are admitted to the hospital. After a year of being enrolled:

Enrollees were admitted to the hospital

25% less



Enrollees went to the emergency room

14% less

*"Enrollees" are all patients ever enrolled, regardless of engagement level.

Top Accomplishments

- Strengthened partnerships with County Government Departments and Community Based Organizations(CBO). This allowed for increase in collaboration with organizations who service the same clients as Kings WPC. Increasing our presence within the community and collaborating with other organizations also allowed for a greater understanding of the target population needs. Through these partnerships we were able to increase information sharing across multiple County departments, CBOS's and Manage Care Providers.

- Automated 100% of enrollee screening and care plans. Automation supported in the improvement of data collection. Improving data collection allowed Kings to clearly define criteria for successful disenrollment's. This allowed Kings WPC to identify specific services and staff positions that were directly contributing to successful linkages of each target population. This also highlighted gaps in data collection and processes that were no longer conducive for current operations.

- Identified gaps in community resources and programs through evaluation of programs service delivery effectiveness and effectiveness of identifying Kings WPC internal benchmarks and performance outcomes. In which created a positive and more strategic plan for the future of WPC.

WPC-LA Accomplishments

1. **Numbers served:**
   - 105,244 unique clients enrolled in WPC programs from 2017 through September 2020.
   - 1,331,209 cumulative member months of service from 2017 through September 2020.
2. **Acute Care Utilization Outcomes:**
   - 27.9% decrease in hospitalization rate per 1,000 Medi-Cal Member Months 6 months after enrollment compared to 6 months before to WPC-LA program.
   - 14% decrease in ED visit rate per 1,000 Medi-Cal Member Months 6 months after enrollment compared to 6 months before to WPC-LA program.
3. **Innovative Programming:**
   - We launched a Transitions of Care Pharmacy program in 2019 to reduce medication-related complications and readmissions by providing post-discharge care coordination support, medication education, and health education and coaching.

Marin County – Whole Person Care

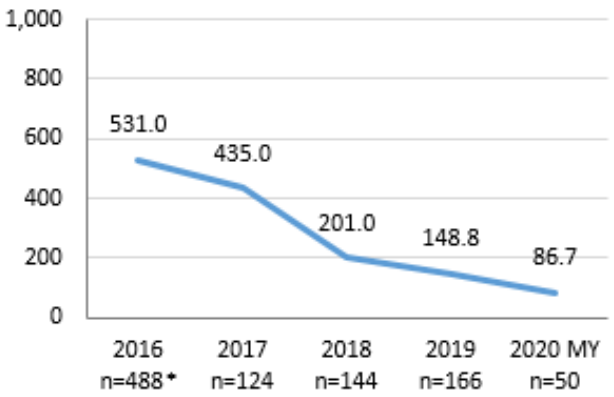
Successes:

- Pair housing vouchers with high-touch WPC case management, creating scattered site permanent supportive housing in order to end chronic homelessness by 2022
- Implement widely used universal client Release of Information
- Implement and use a cross-domain care coordination platform

WHOLE PERSON CARE
MONTEREY COUNTY
Physical Wellness • Behavioral Health • Social Services

Reduced ED Visits

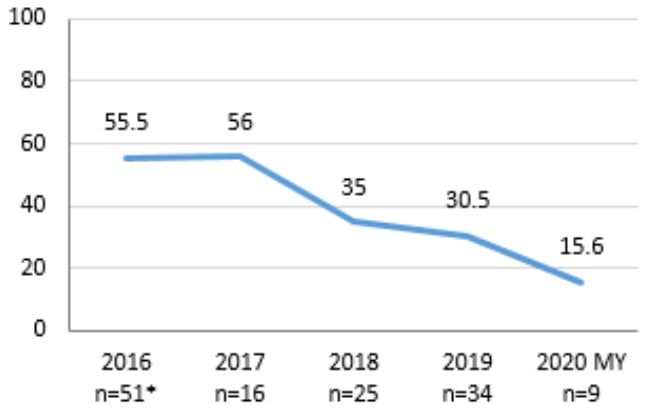
WPC Enrollee ED visits per 1,000 Member Months
Monterey County, 2016 to 2020



*2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2020. Prepared by Monterey County Health Department, September 2020

Reduced Inpatient Discharges

Enrollee Inpatient discharges per 1,000 MM
Monterey County, 2016 to 2020



*2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2019. Prepared by Monterey County Health Department, September 2020

1,015 People

annually received direct services and/or warm referrals for health and mental health, financial benefits, meals, emergency shelter, housing, transportation, legal assistance, and life skills education

254 People

with complex chronic disease and/or mental health needs received coordinated Public Health Nursing Case Management

39% of people receiving Public Health Nursing Case Management were helped into transitional, supportive, or permanent housing

Riverside Top 3 Accomplishments

- 83% of newly released inmates consented to screening and referral for SUD, BH, PH, Social Services and housing needs.
- Reduction of re-incarceration by 64% in the population that attended at least one appointment when referred to the Department of Behavioral Health.
- At baseline, <5% of probationers who qualified for Medi-Cal were enrolled, RUHS WPC was able to get 65% of those who qualified enrolled.

Riverside University HEALTH SYSTEM

City of Sacramento's Whole Person Care (WPC) Pilot Accomplishments

- As of October 2020, the Sacramento WPC pilot **successfully housed 869 enrollees,** 516 individuals are permanently housed and 353 are transitionally housed.
- The Sacramento WPC pilot developed a **cloud-based data sharing platform** that supports an efficient co-management model between health care, housing and community-based organization (CBO) partners.
- Strong relationships amongst the Sacramento WPC pilot's collaborative enabled the program to continue **serving enrollees during the early days and throughout the COVID-19 pandemic**.

PROJECT ACCOMPLISHMENTS

90% permanent housing retention rate, an increase of 58% over prior year annual reporting

22% decrease in the number of days spent in the County's psychiatric inpatient unit

43% decrease in the number of incarcerations

26% decrease in the number of days spent in the hospital

40% decrease in the number of Emergency Department visits

SAN FRANCISCO WHOLE PERSON CARE 2020 SUCCESSES


Shared Priority Workgroup

Interagency collaboration through the "Shared Priority" project represents the cross-agency collaboration forged through Whole Person Care. Three City departments - Health, Housing, and Human Services - adopted a "whatever it takes" approach to place 237 of SF's most vulnerable clients experiencing homelessness into housing or other safe settings. Integrated data was leveraged to identify, wraparound, and monitor outcomes for shared clients. with the goal of better understanding which services are most effective and how to better work together as a system.


Mobile teams at work

Interagency data sharing tool: SF WPC is transitioning integrated health, housing, and social information from the Coordinated Case Management System (CCMS) – DPH's long standing system - to Epic. The implementation of Epic's Coordinated Care Management (CCM) toolset went live Nov 9 and will make integrated data more accessible at the point of care, as well as for reporting.


Creative workspace in SIPs

COVID-19 Response: Interagency partnerships and data infrastructure forged and implemented through SF Whole Person Care, made the SF WPC team critical in the response to the COVID-19 pandemic. SF leveraged integrated data to identify individuals at higher-risk for coronavirus complications for placement in alternative housing settings. Partnerships and learnings from SF's WPC pilot informed the model of care in SIP hotels, as well as outreach work with unsheltered people experiencing homelessness.

San Joaquin County Whole Person Care

- Ability to share and coordinate linkage and services between community partners due to WPC Consent form.

- Ability to identify and assist those most at risk in our community with coordinated efforts from the shelters, hospitals, Public Health, Behavioral Health, County jail, District Attorney's office, etc. including building relationships and contacts within each of these entities to ensure continuity of care and coordinated care.

- Ability to be a true advocate and build the relationship with the client and then be able to assist them into services including linkage to treatment.

The County of Santa Clara Health System's - Whole Person Care Program

INNOVATIVE PROJECTS – Projects designed to improve patient access for special needs & transitions of care

SUSTAINABLE

- Skilled nursing homes (SNFs) transitions, diversions and care coordination
- Intensive Primary Care
- Peer respite
- Sobering center and mental health and drug triage
- Substance use disorder (SUD) identification and intervention in ambulatory clinics, ED and inpatient settings

PROMISING

- Prediabetes identification and education partnership with ambulatory clinics and YMCA
- Integration of public health efforts in chronic disease prevention and control into primary care settings (on hold due to COVID)

NOT SUSTAINABLE

- Social Services Agency (SSA) referrals for mental health care at SSA point of contact for SSI/General Assistance applicants
- Incentive designed to support increased transitions of patients with medical and psychiatric issues from hospital to SNFs

COUNTY OF SANTA CLARA
Health System

County of Santa Cruz
Whole Person Care – Cruz to Health
Top Accomplishments

- Bridging the Care Coordination Gap
  - Collaborations with internal and external partners, improved communications and information sharing. Successful launch of the care coordination on-line platform, Together We Care.
- Case Management “Plus”
  - In-depth and hands-on work necessary to secure stable housing. Close coordination with Housing Navigation team and housing supports.
- Peer Support Program
  - Creating social connections and critical supports to maintain housing.

California Small County Collaborative Whole Person Care Pilot

Mariposa and San Benito Counties

December 2017 - June 2020

Whole Person Care
California Small County Collaborative

130
Clients Served

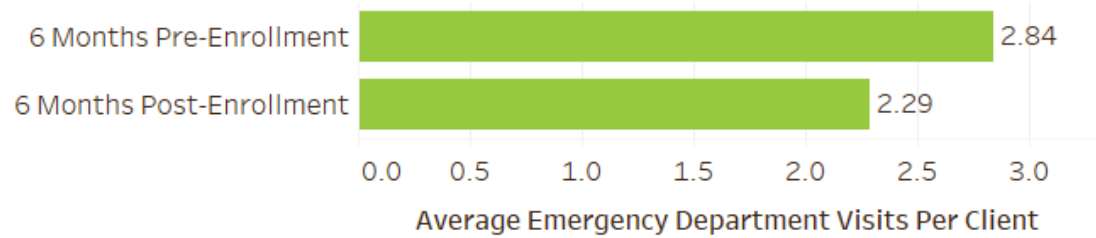
74%
Connected to Primary Care

72%
Met Goals After 3 Months in Program

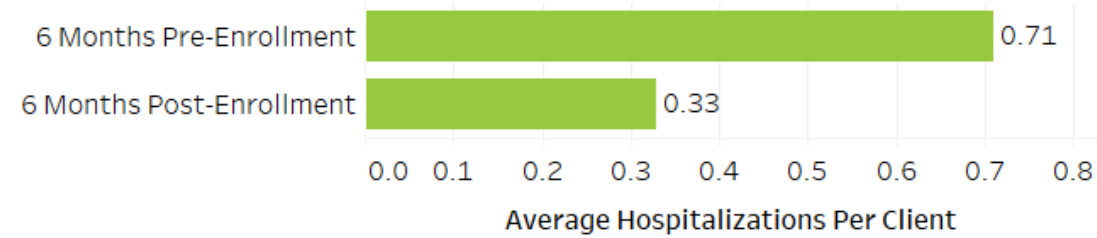
34
Homeless Clients Housed

27
Clients Graduated

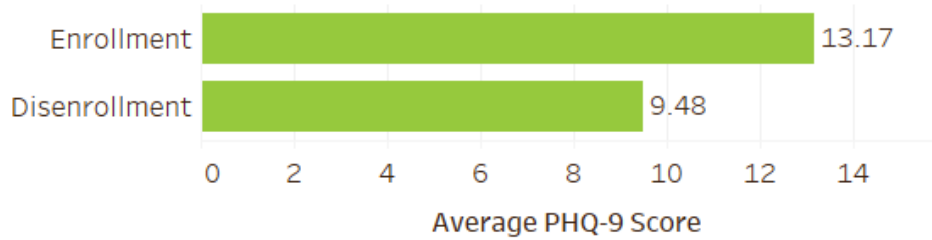
19% Decrease in ED Visits in First 6 Months in Program



54% Decrease in Hospitalizations in First 6 Months in Program



33% Decrease in PHQ-9 Score from Enrollment to Disenrollment



Key Factors for Success:

Stabilization of Medication Use
Housing
Setting and Meeting Goals

TOGETHER WE CAN

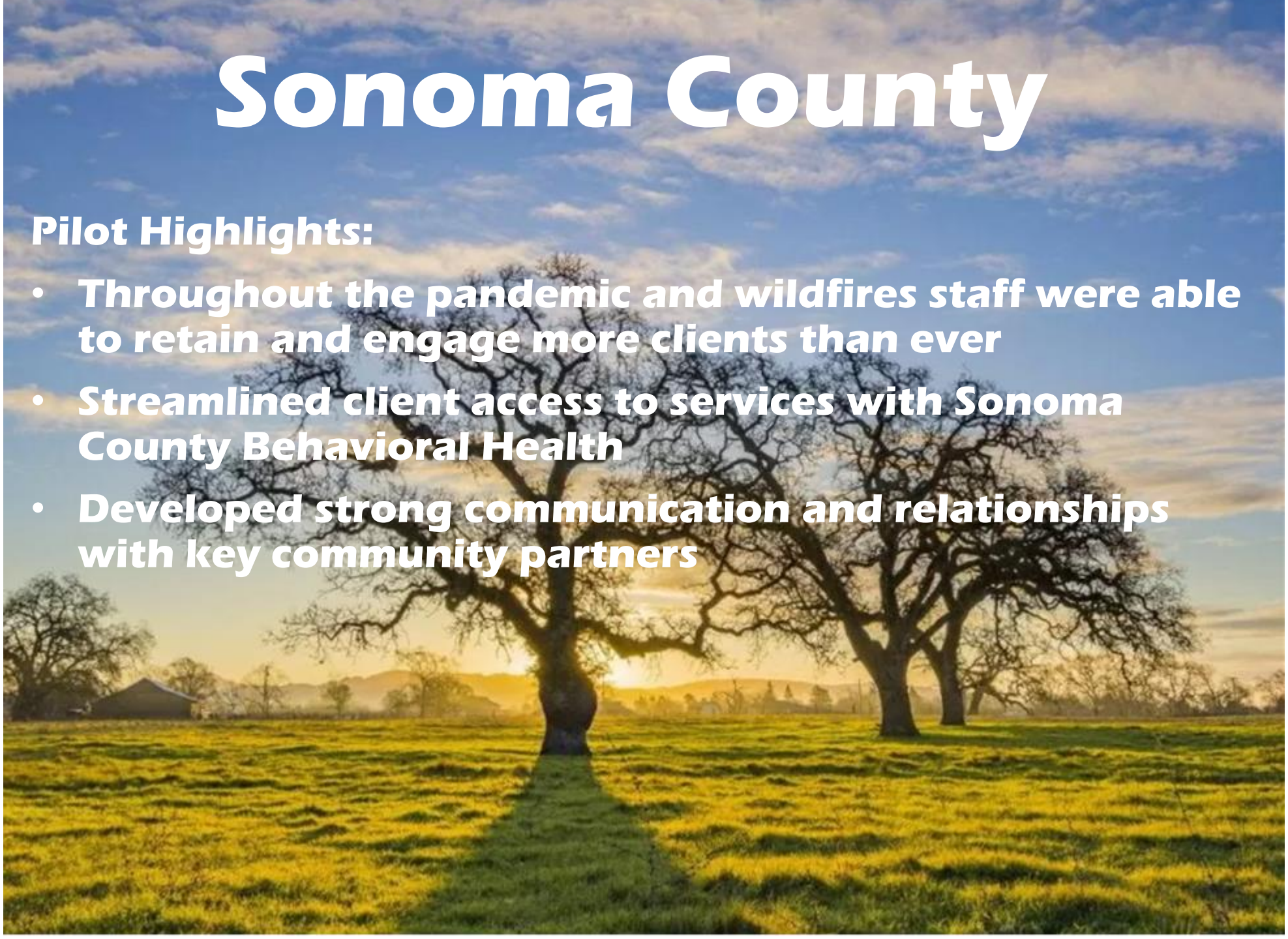
Solano County increased the number of Clients Graduating from Whole Person Care.

Built community partnerships with housing, medical care, hospital emergency rooms, social services, transportation, Partnership Healthplan that resulted in supporting clients to reach their goals

Surpassed our goal of number of clients housed, with more than half of clients housed were in permanent housing

Supported clients to connect with their primary care provider and specialty care appointments resulting in less emergency room visits

Sonoma County



Pilot Highlights:

- **Throughout the pandemic and wildfires staff were able to retain and engage more clients than ever**
- **Streamlined client access to services with Sonoma County Behavioral Health**
- **Developed strong communication and relationships with key community partners**