Whole Person Care Appreciation Event

December 9, 2020

Agenda

- **1:05-1:30: Keynote**
  - Jacey Cooper, Medicaid Director and Chief Deputy Director of Health Care Programs, DHCS
  - Catherine Teare, Associate Director, High-Value Care, CHCF
- **1:30-2:15 Pilot Highlights**
  - Riverside County
  - Santa Cruz County
  - San Diego County
  - San Francisco County
- **2:15- 2:30: Unsung Hero Awards**
- **2:30-2:50: Appreciations and Shout-outs/Discussion**
  - Pilot leads and staff can take this time to reflect aloud on their experiences this far in the pilot.
- **2:50-3:00: Looking Ahead**
  - DHCS and WPC Staff
- **3:00: Adjourn**

Jacey Cooper

Medicaid Director and Chief Deputy Director of
Health Care Programs
Department of Health Care Services

Enrollment Highlights

- In PY4, pilots reported successes in identification, engagement, and enrollment of the target populations.
- As of June, WPC pilots had enrolled over 190,000 Medi-Cal beneficiaries.
- Eight pilots have surpassed their enrollment goals.

Lead Entity	Pilot Enrollment Goal*	Cumulative Enrollment (as of June 2020)	Percent of Goal Achieved (%)
Monterey	412	601	145.9%
Orange	9,303	11,708	125.9%
Sonoma	2,100	2,521	120.0%
Alameda	17,000	19,703	115.9%
Kings	600	692	115.3%
Contra Costa	42,000	47,250	112.5%
San Diego	800	839	104.9%
Placer	450	464	103.1%
Solano	250	240	96.0%
Kern	2,000	1,857	92.9%
Santa Cruz	625	556	89.0%
San Joaquin	2,255	2,006	89.0%
San Mateo	4,141	3,675	88.7%
San Francisco	22,600	19,232	85.1%
Los Angeles	70,000	58,672	83.8%
Shasta	600	429	71.5%
Mendocino	550	391	71.1%
Napa	800	568	71.0%
SCWPCC	195	138	70.8%
Riverside	10,018	6,940	69.3%
Santa Clara	9,000	5,886	65.4%
San Bernardino	2,120	1,236	58.3%
Marin	3,200	1,783	55.7%
Sacramento	3,787	2,023	53.4%
Ventura	2,546	1,279	50.2%
Grand Total	**207,352**	**190,689**	
*enrollment goals were updated in PY3 based on pilot projections			

Care Coordination Highlights

- The number of WPC enrollees that received a comprehensive care plan within 30 days of enrollment increased from 12% to 27% from PY 2 to PY 3.

- Pilots have reported successes in the development of case management platforms, integrating electronic health records, and using real time notifications to support care coordination efforts.

- Almost all pilots have reported success in the development of new data sharing tools, data sharing with WPC partners, and utilizing the data to inform outreach and care coordination activities.

Improved Health Outcome Highlights

- ED visits, hospitalizations, and all-cause readmission rates were steeply increasing prior to WPC enrollment and to some extent during the first year of WPC enrollment but began declining in PY 2.
- Pilots have experiences increased the the number of beneficiaries who follow-up after hospitalization for mental illness and initiate and engage in alcohol and other drug dependence treatment.
  - Among PY 2 enrollees who enrolled during 2017, follow-up after hospitalization for mental illness at 30 days increased from 73% in Pre-WPC Year 2 to 83% in WPC Year 2.
- Beneficiaries self-report improved overall and emotional health, blood pressure control, and diabetes control from baseline measurements.
  - WPC pilots saw increased in the percentage of enrollees who reported being in excellent or very good overall health (8% to 22%) and emotional health (15% to 22%).
  - Enrollees reporting controlled blood pressure among increased from 36% to 65%
  - Enrollees with controlled HbA1c increased from 52% to 58%

Impact on Individuals Experiencing Homelessness

- Nearly half of WPC enrollees are experiencing homelessness upon engagement in a pilot.

- **Decreasing rates of ED visits.** Among homeless PY 2 enrollees, unadjusted rates of ED visits in the two years **prior to WPC** showed utilization increasing from 219 to 267 visits per 1,000 Medi-Cal member months. In PY 1, this was followed by a lesser increase (271) and eventually a decrease to 217 in PY 2.

- **Decreasing rates of hospitalization.** Among homeless PY 2 enrollees, unadjusted rates of hospitalization in the two years **prior to WPC** showed an increase in utilization from 68 to 81 visits per 1,000 Medi-Cal member months. In PY 1, this was followed by a lesser increase (86) and in PY 2 a decrease to 66.

Q&A

Presentation of WPC Appreciation Certificates

Catherine Teare

Associate Director, High-Value Care
California Health Care Foundation

Pilot Highlight Presentations

- Riverside County
- Santa Cruz County
- San Diego County
- San Francisco City/County

Coordination of Care in the Justice Involved Population

Judi Nightingale, DrPH, RN
Director, Population Health
Riverside University Health System

Riverside County WPC

- Goals:
  - To reduce re-incarceration
  - To reduce unnecessary ED use
  - To get active Medi/Cal benefits
- Method:
  - Screening RNs imbedded into all Probation/Parole sites
  - Screened for: physical, mental, SUD, social service and housing needs
  - Referral to needed resources
  - High needs clients enrolled into WPC Care Management-Care Manager embedded into all Community Health Clinics
  - WPC Housing outreach specialists embedded throughout the County

Riverside University HEALTH SYSTEM

Riverside County WPC Pilot's Top Accomplishments

- 83% of newly released inmates consented to screening and referral for SUD, BH, PH, Social service and housing needs.
- Reduction of reincarceration by 64% in the population that attended at least one appt when referred to DBH.
- At baseline, <5% of probationers who qualified for M/Cal were enrolled. At it's highest reporting cycle RUHS WPC was able to reach 65% of those who qualified, accessing active Medi/Cal benefits.

Riverside University HEALTH SYSTEM

Screenings

Riverside University HEALTH SYSTEM

Screenings/Site

Screening Site	Initial Screening Offered	Screening Accepted	Declined	% Accepted
BLYTHE	9	9	0	100%
EAST	80	61	19	76%
WEST	94	75	19	80%
PALM SPRINGS	370	295	75	80%
BANNING	838	526	312	63%
CORONA	1,004	768	236	76%
SAN JACINTO	1,694	1,478	216	87%
MURRIETA	1,821	1,712	109	94%
INDIO	1,915	1,699	216	89%
MORENO VALLEY	2,642	1,880	762	71%
RIVERSIDE	3,449	3,013	436	87%
Totals:	13,916	11,516	2,400	83%

Riverside University HEALTH SYSTEM

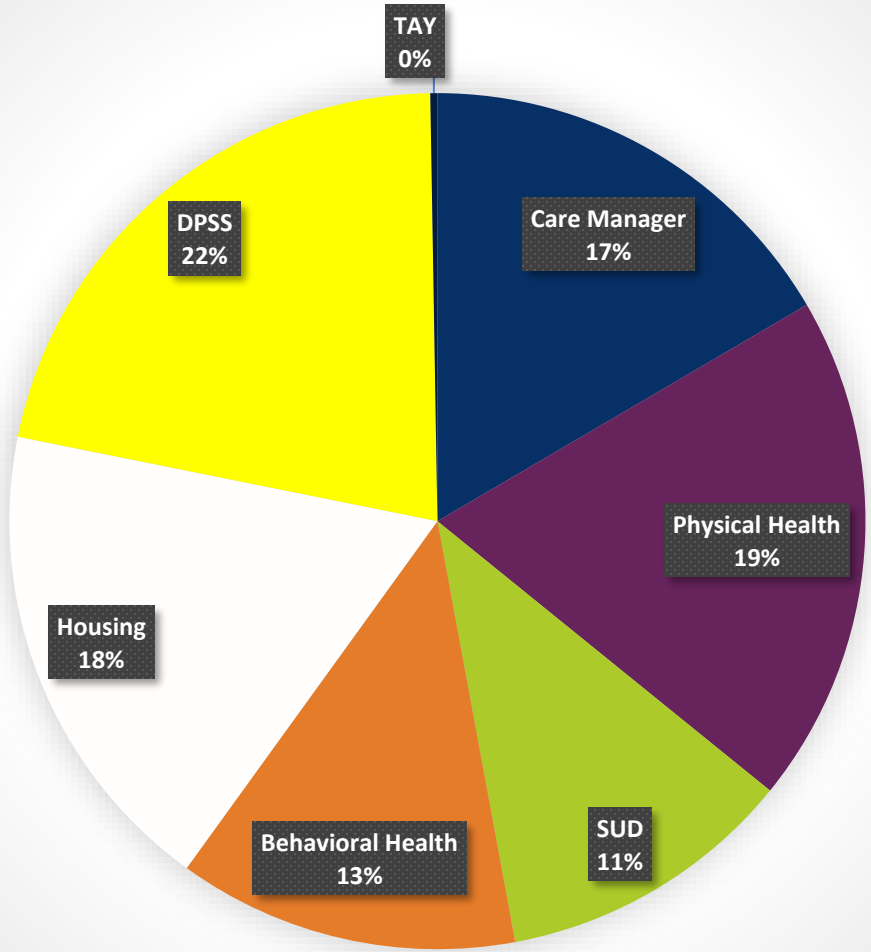
Referrals

Screening Site	Total Referrals	Care Manager	Physical Health	SUD	Behavioral Health	Housing	DPSS	TAY
BANNING	652	207	217	92	62	93	188	0
WEST	134	106	54	9	26	29	16	0
BLYTHE	13	4	2	1	2	4	4	0
EAST	126	74	28	7	33	41	17	0
MURRIETA	1,463	276	376	210	234	318	324	1
PALM SPRINGS	446	84	122	58	51	100	114	1
SAN JACINTO	3,960	591	1,103	417	595	963	879	3
INDIO	2,378	423	451	243	391	758	531	4
CORONA	1,144	327	381	166	164	160	266	7
MORENO VALLEY	2,480	869	468	523	409	576	490	14
RIVERSIDE	3,797	334	630	512	593	578	1,461	23
Totals:	16,593	3,295	3,832	2,238	2,560	3,620	4,290	53

Riverside University HEALTH SYSTEM

Percentage of Referrals

Referrals:



Riverside University HEALTH SYSTEM

Success Story

- **The Challenge** The client's pet snake was seized when she went to jail. The client was in jail for approximately 30 days & Animal Control only holds snakes 10 days. The snake was taken by a rescue and then adopted out. The client was very upset that her pet snake was gone & that she would be unable to get it back. She had bonded with that snake and really, really wanted the snake back. She was unable to concentrate & extremely distracted from the loss of the snake.

- **The Solution** Over the course of several months, the RN Care Manager worked with Animal Control & the client to obtain/adopt another snake.

- **The Result:** The client was given the opportunity to adopt another snake after she showed effort toward her own self-care. She followed all the necessary steps to get the snake. That included a long drive into Riverside, but the client did it. She appears happier & recently shared that she took the snake (Phy-Is) on a bike ride.

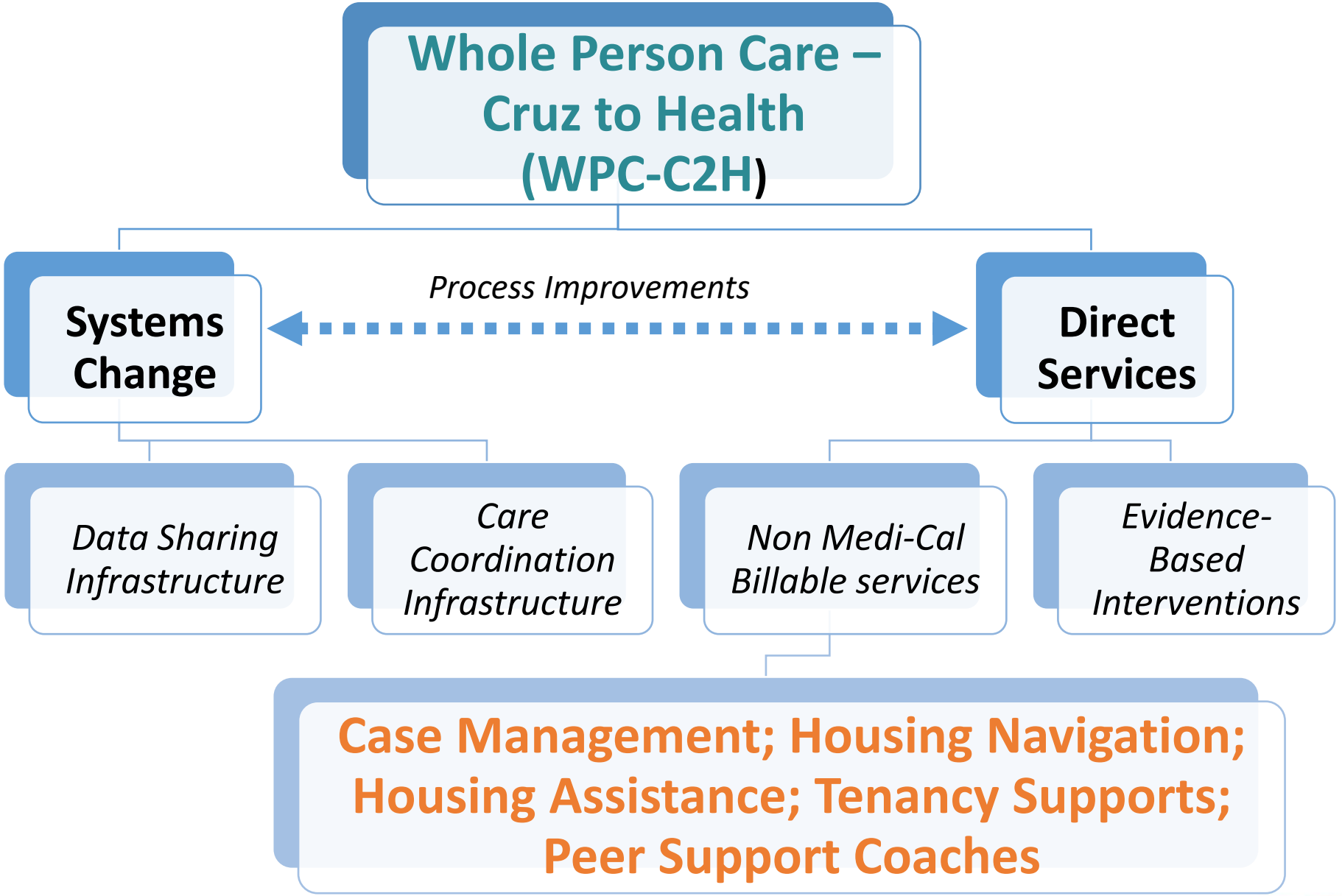
Riverside University HEALTH SYSTEM

County of Santa Cruz Whole Person Care – Cruz to Health

Housing Success Through Relationships: the Role of the Housing Navigator

Lynn Lauridsen, MPH
County of Santa Cruz Health Services Agency
December 9, 2020

WHOLE PERSON CARE
CRUZ TO HEALTH


Whole Person Care – Cruz to Health (WPC-C2H)
Systems Change
Process Improvements
Direct Services
Data Sharing Infrastructure
Care Coordination Infrastructure
Non Medi-Cal Billable services
Evidence-Based Interventions
Case Management; Housing Navigation; Housing Assistance; Tenancy Supports; Peer Support Coaches

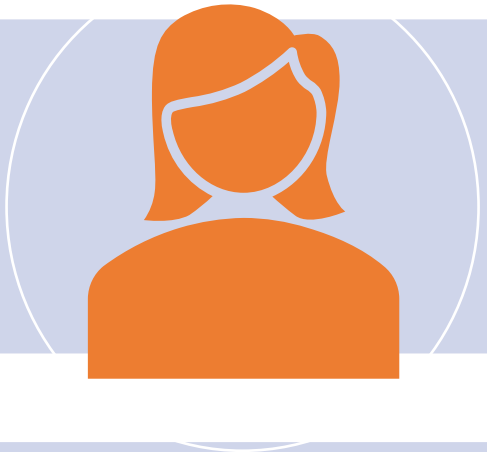
Profile of an Enrollee

Medical Health

- Medically disabled
- Chronic medical condition
- Non-compliant
- Older adult
- Banned from local SNFs
- High ED utilization

Behavioral Health

- Severe Depression
- Past traumas
- Substance Use Diagnosis



Social Determinants of Health

- Homeless ~5 years
- Extremely low income
- Demanding with caretakers
- Unreliable transportation
- History with criminal justice
- Difficult to engage
- Person of color

WPC-C2H Services for At-risk for Homelessness and Homeless Enrollees

Case Management

Care Coordination, Case Conferencing, Integrating behavioral, medical health, and social determinants of health

Tenancy Supports

Goods, services, and housing set-up expenses

Intensive + Intermediate Housing Support Bundles

Housing Navigation and/or Peer Support Coaches

Housing Assistance

Security deposit and/or first month's rent

Connecting The Housing Puzzle Pieces

ENROLLEE

- Housing readiness
- Engagement and investment into process
- Numerous appointments and paperwork
- Attend landlord interviews

HOUSING NAVIGATOR*

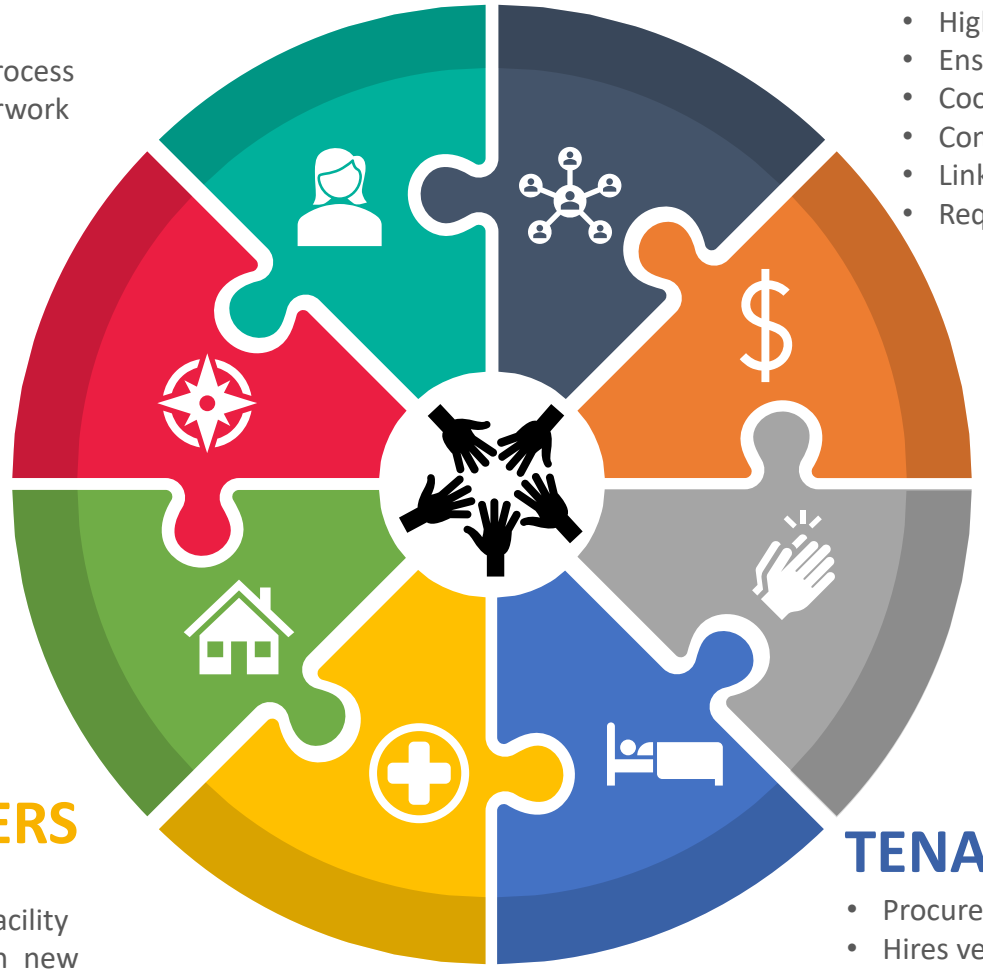
- Enrollee intake and interface
- Housing Search (ADA appropriate)
- Networking with landlords/Craigslist posting
- Transport and attend appointments with enrollee & landlord
- Lease/move-in negotiations

HOUSING AUTHORITY

- Issues Disabled and Medically Vulnerable Voucher (Section 8)
- Inspects and approves housing for suitability

PROVIDERS

- Stabilize client's medical and behavioral conditions
- Ensure readiness to transition from Skilled Nursing Facility
- Recommend adaptations and devices necessary in new home



WPC-C2H CASE MANAGER*

- High touch engagement and outreach with enrollee
- Ensure connection to benefits advocacy and assistance
- Coordinate medical, behavioral health appointments and care
- Complete housing voucher paper and documentation
- Linkage and referral to resources
- Request deposits, tenancy supports

HOUSING ASSISTANCE*

- Issue deposits
- Issue first months rent
- Rapid turnaround in a hot housing market

PEER SUPPORT COACH*

- Assist with transportation, appointments, activities of daily living
- Provide social and/or emotional support
- Build rapport, trust
- Role model positive behavior
- Communicates with other care team members

TENANCY SUPPORTS*

- Procures necessary items – furniture, supplies
- Hires vendors for services – movers, installation of environmental adaptations

*Service funded through WPC pilot program

WHOLE PERSON CARE
CRUZ TO HEALTH

Client Challenges

- Lack of familiarity with the housing process
- Lack of access to internet connection and computers
- Lack of transportation
- Physical disabilities
- The County's tight housing market
- Stigma

Housing Navigator

The two WPC-C2H Housing Navigators maintain ongoing relationships with a portfolio of local landlords who reach out to them with openings. They serve as matchmakers, connecting a landlord's specific needs and concerns with a client's needs and local availability of a social support system.

"We can give you an opportunity to have a home, not just four walls but with new sheets, towels, dishes, all the things a person needs to start a new home...To start from that rather than a scarcity place...how much more humane and beautiful and holistic is that?"
– WPC-C2H Housing Support Team Supervisor

"We sat there while she signed the lease and she cried and we took pictures and she was so thankful. We are giving her the chance to save face, have her own space, focus on other things for herself, feel safe, and do things for herself again."
-WPC-C2H Case Manager

"I got a text from a client that says, 'Thank you for everything you do. I feel so human when I'm around you.'"
- WPC-C2H Case Manager

"I wouldn't have been able to talk to the landlord without the Housing Navigator. I probably would have lost the place."
- WPC-C2H Client

Core Component: Relationships

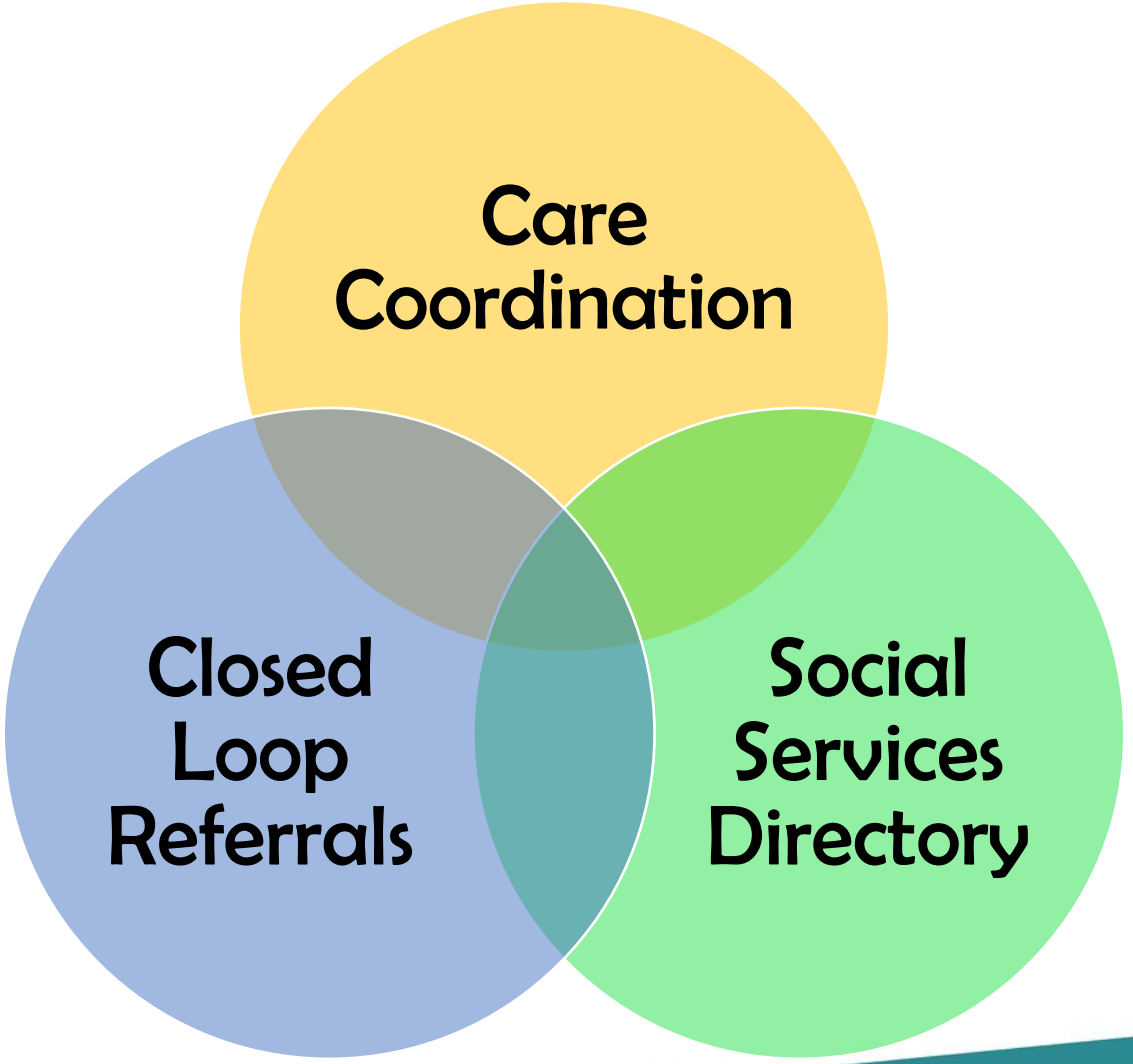
Documenting the Relationship

- One place where team members can record and view the work of each team member
- Chronological record of progress
- Store important documents for easy access
- Assign tasks

Santa Cruz Health Information Organization
Together We Care

“Together We Care” Platform

- Care Management and Community Resource Referral System
- Seamless communication
- Share patient information
- Coordination of tasks across the care continuum
- Multidisciplinary partners



Core Components

RELATIONSHIPS

- ✓Support for the “whole person”
- ✓Collaborative team culture

HOUSING AND FINANCIAL RESOURCES

- ✓ Access to subsidized housing vouchers
- ✓ Financial housing assistance for first month’s rent, deposit and application fees
- ✓ Tenancy supports for home furnishings and supplies

Acknowledgements

Whole Person Care – Cruz to Health Team

Front Street Inc. Administration, Housing Navigators, and Peer Support Coaches

And numerous community partners and stakeholders

COUNTY OF SAN DIEGO WHOLE PERSON WELLNESS

Housing Retention Makes for Better Health Outcomes

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO VISION

LIVE WELL SAN DIEGO

Building Better Health

Living Safely

Thriving

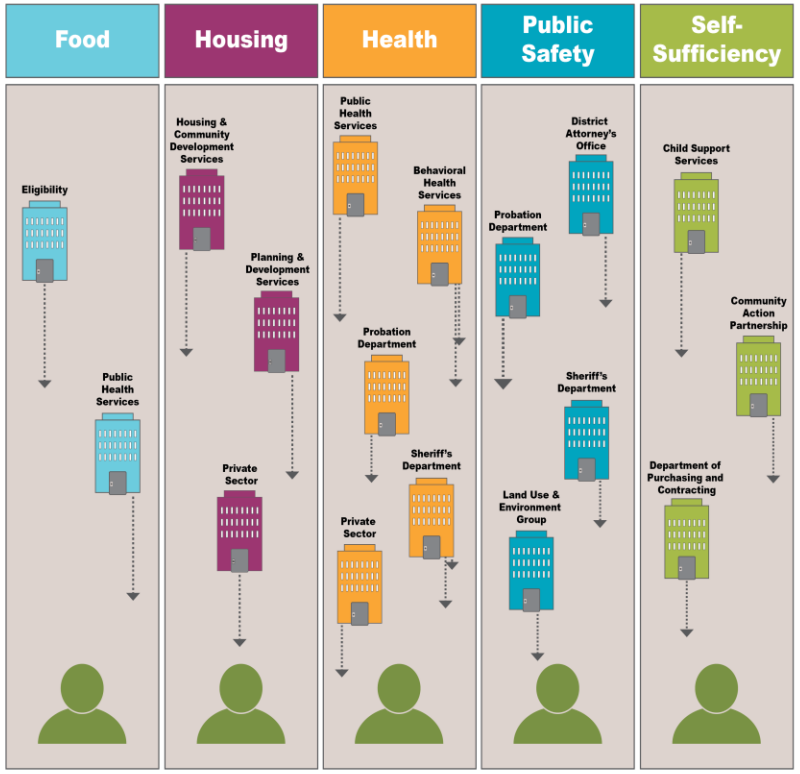
INTEGRATIVE SERVICES

To enable every San Diegan to live well and with dignity

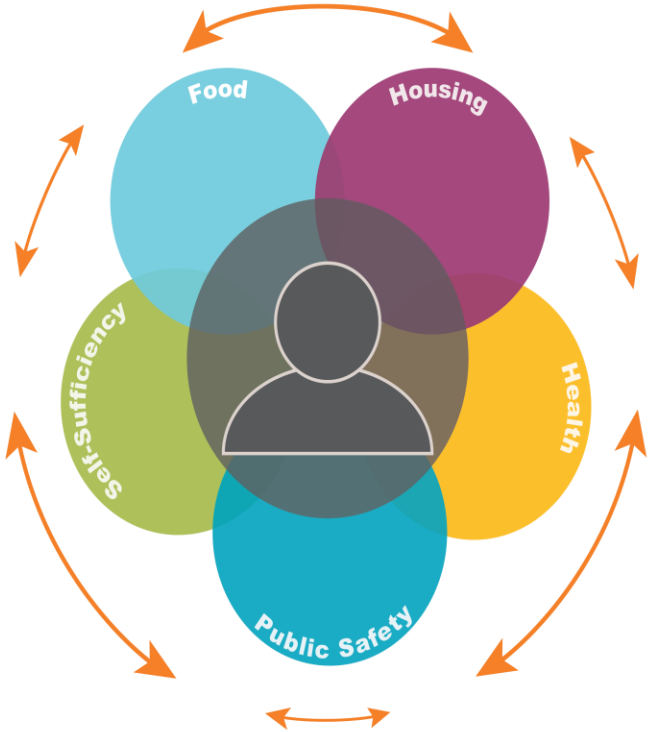
LIVE WELL SAN DIEGO

PERSON-CENTERED APPROACH

Current: Some Cooperation, Some Silos



Integrative Services: Person-Centered Solutions



WHOLE PERSON WELLNESS

*We serve: Individuals who are homeless/at-risk of homelessness, with a behavioral health, substance use disorder, and/or chronic physical health condition

*Filling a gap in our local homeless and mainstream medical systems

*Creating connections between managed care, social services, hospital system, law enforcement, HMIS, County services

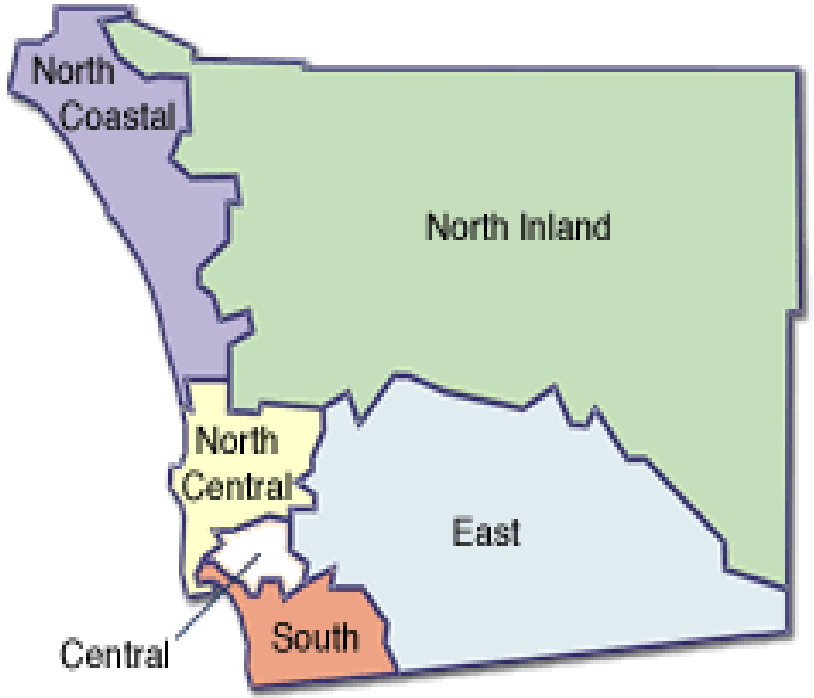
*Instituting a Care Coordination model for use with similar high-need populations

LIVE WELL SAN DIEGO

PILOT OVERVIEW

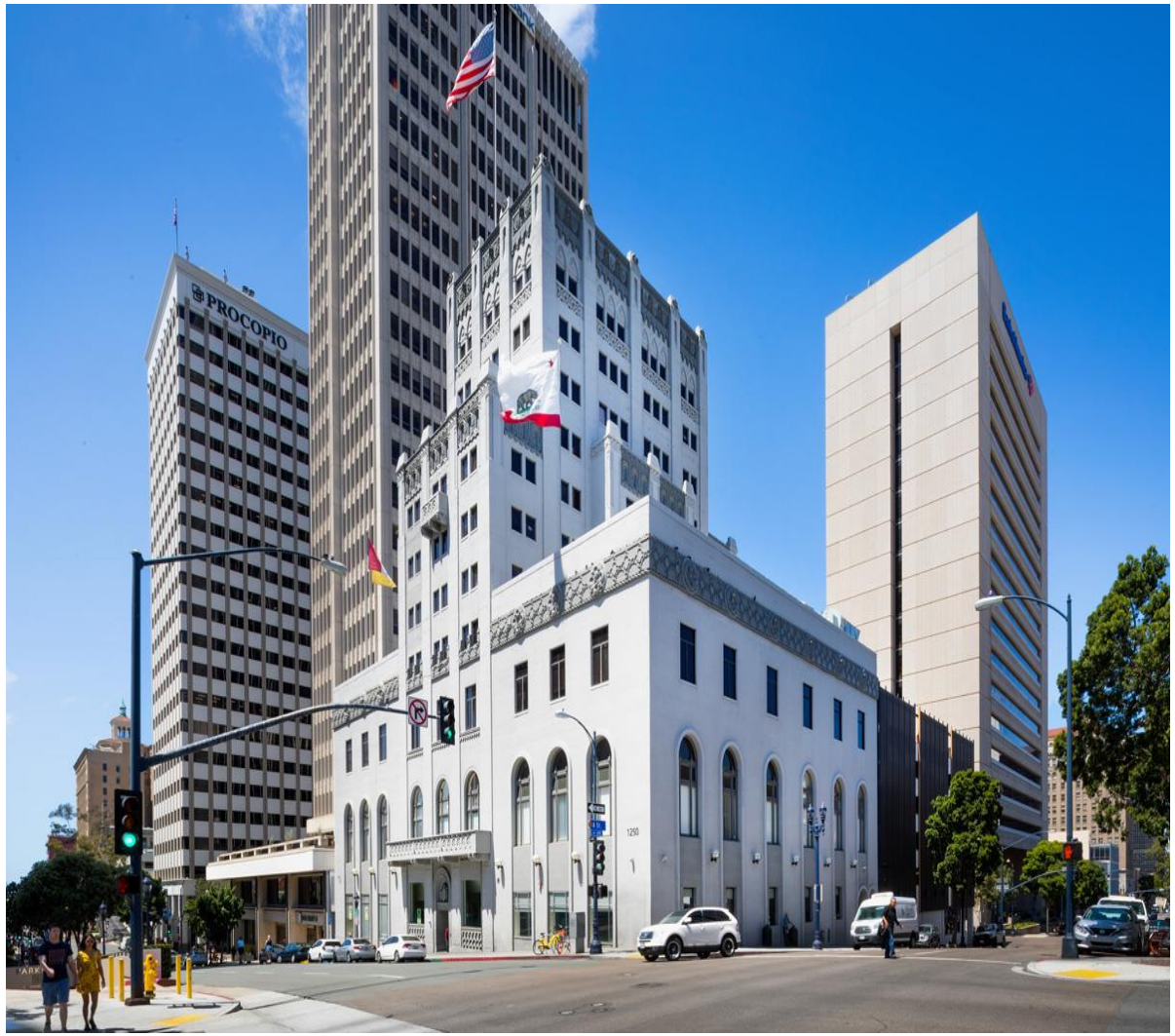
ALL SERVICES ARE CONTRACTED OUT FOR

COUNTY-WIDE COVERAGE



WHOLE PERSON WELLNESS

PATH
MAKING IT HOME



LIVE WELL SAN DIEGO

EXODUS RECOVERY

The pathway to freedom begins with you.

WHOLE PERSON WELLNESS

SERVICE INTEGRATION TEAMS

1:25 Case Ratio

Housing Navigator

Clinician

Case Manager

Peer Support Specialist

HIGH ACUITY TEAMS

1:10 Case Ratio

Housing Navigator

Clinician

Case Manager

Peer Support Specialist

INTEGRATING HOUSING SUPPORTS

Incorporated **Housing Disability Advocacy Program** (**HDAP**) into our contracts:

***Flexible Housing Supports**: hotel/motel, SRO, shared housing, move-in costs, secondary security deposits, home habitability improvements, utility assistance & storage fees

***Rent Subsidies**: at 30% of income

***Individual Expense Cap** at $9,000, option for approval to exceed the cap

***Legal Aid Society of San Diego**: Direct Connect to Disability Advocacy

WHOLE PERSON WELLNESS

WHOLE PERSON WELLNESS

HOUSING ACCOMPLISHMENTS

*90% permanent housing retention rate at 6 months, an increase of 58% over prior year annual reporting

*80% retention rate at 12 months

*63% of those ever enrolled have been housed

*51% of enrollees have been permanently housed

HOUSING IS HEALTHCARE

*26% decrease in number of hospital days project-wide, 28% for those who were housed

*40% decrease in Emergency Department visits project-wide, 42% for those who were housed

THANK YOU!

AMARIS SANCHEZ
PROGRAM COORDINATOR
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LIVE WELL SAN DIEGO

SAN FRANCISCO WHOLE PERSON CARE

Shared Priority Project

December 9, 2020

Shared Priority Goal:

Health, Housing, and Human Services will adopt a "whatever it takes" approach to place our most vulnerable clients experiencing homelessness into housing or other safe settings.

Street-to-Home

1

311 →SFHOT → Street Outreach Team

2

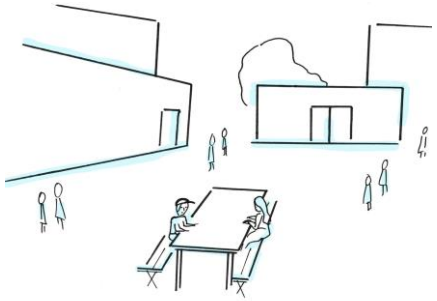
Case Conference → Street-to-Home Plan

3

PES → Care Team Coordination

4

Hummingbird → Residential Treatment



5

Navigation Center → Home

What we hoped to learn from Shared Priority 1.0

Outcome Metrics

- Placement into housing or other safe setting
- Engagement in behavioral health treatment services
- Score on Adult Needs and Strengths Assessment (ANSA)
- Use of Urgent/Emergent Services
- Enrollment in benefits and SSI advocacy

Pilot Evaluation

- Did we reach Change Management goals?
- Did we improve staff perception of Interagency Collaboration?
- Was pilot methodology effective?

Shared Priority Bi-Weekly Dashboard

12-03-2020

Population
237 individuals
5 no service util/SP contact since start of project
19 deceased

Case Managed
56 start
134 currently

Housed
6 start
6 lost housing
151 currently

LPS Conserved
4 currently

Urgent/Emergent Services

ED	Inpatient	Sobering Center
10	3	0
+2	-3	0
11 visits **Nov 17 - Nov 30**	**3 stays** **Nov 17 - Nov 30**	**0 visits** **Nov 17 - Nov 30**

PES	5150	Jail
4	4	3
+2	+4	0
4 visits **Nov 17 - Nov 30**	**0 hold** **Nov 17 - Nov 30**	**3 stays** **Nov 17 - Nov 30**

Living Situation

Unknown	Not Sheltered	Temporarily Sheltered		Housed	
23	14	25	5	143	8
0	-1	0	0	0	0
No service util in 30 days	Service util/contact in last 30 days	Nav/Shelter/Stab Room/ SIP Hotels	Treatment/ Respite	HSH PSH, Scattered Site/Flex Pool, Sec 8	Board & Care, Left SF, Self Resolved

Engagement

Case Management		
35	42	57
0	0	-1
Outpatient Case Management	Citywide Linkage ICM	Intensive Case Management

Housing Process

Housing Navigation	Assigned Housing Unit
192	22
	+1
HSH Housing Svcs Oct 2019 - Nov 2020	Awaiting PSH move-in

Benefits

CAAP	SSI		Medi-Cal	CalFresh	IHSS
59	75	67	195	142	26
-	-3	-0	-7	-	-
Enrolled As of Nov 14	Enrolled in SSI As of Nov 30	Advocacy	In and out of county As of Nov 30	Enrolled As of Nov 13	Enrolled As of Nov 13

↑ ↓ INDICATES FAVORABLE DIRECTION

+/- CHANGE SINCE PREVIOUS 2 WEEK REPORTING PERIOD

NO UPDATE SINCE PREVIOUS 2 WEEK REPORTING PERIOD

Key Learnings

Shared Priority Client outcomes

- **5** clients have had no service utilization or SP contact since start
- **134** clients are connected to DPH case management
- **192** clients have received housing navigation services from HSH
- **151** clients have been housed and **22** have been referred to housing
- **19** SP clients have deceased

System improvements

- Increased collaboration between teams
- Increased understanding of processes
- Compiled and leveraged data across systems for care coordination and evaluation
- Identified recommendations for system and agency improvements based on the experience and needs of SP clients

Provider Reflections: Successes

The **Shared Priority "label" is effective** in opening doors that wouldn't normally be opened.

The Shared Priority project is helping teams **shift their mindset to be creative and flexible** when caring for vulnerable clients.

A **shared population clarifies goals** and encourages providers to work together.

Teams are **developing a better understanding** of each others' systems.

The project took time to set up the appropriate infrastructure and engage the right partners**—but now it's working**.

High intensity care coordination is making a difference! The ability to refer clients directly to street-based engagement and linkage teams **is essential**.

Individuals are getting help that they otherwise wouldn't get if this project didn't exist.

What's next for the Shared Priority project?

Iterate and refine data-driven, interagency collaborations to identify and wrap-around Whole Person Integrated Care's (WPIC) highest risk shared clients.

Shared Priority 2.0

- Identify a cohort of clients residing Shelter-in-Place hotels who are Housing Referral status ready and were in the original MHSF cohort.
- Pilot and scale the use of a shared toolset (Epic CCM) to facilitate communication and care coordination across interagency teams.
- Align with City efforts to place SIP clients in housing, leverage stability of client location and care coordination occurring in SIPs.
- Identify clinical success metrics for clients and CCM adoption.
- Inform future vision for WPIC Health Resource Center service model.


EPSON

Unsung Hero Awards

Unsung Hero Award Recipients

Aasha Abbott, Santa Cruz County

Anira Khlok, City of Sacramento

Dolores Gonzalez, Riverside County

Geno Robledo, Kings County

Holly Webb, City of Sacramento

Jaime Rios, Santa Clara County

Jodi Nerell, City of Sacramento

Katherine Werner, Riverside County

Linda Raygoza, Kern County

Mario Luna, San Bernardino County

Neil Kurtz, City of Sacramento

Noemi Perez, San Benito County

Rebecca Alvarado, Alameda County

Tari Dolstra, Riverside County

Vanessa Wentwoord, Solano County

Maria X. Martinez, San Francisco

In memoriam

Appreciation, Shoutouts and Discussion

Please raise your hand if you would like to share, we will unmute you

Looking Ahead and Closing Remarks

Dana Durham, DHCS

THANK YOU