Whole Person Care

Pathway to Independence and Wellness

California Small County Collaborative

San Benito County

Program Summary

November 15, 2017

Part I - Background

San Benito County

- Approximately 58,792 residents
- 19,023 Medi-Cal eligible, 32% residents
- Heath and Human Services Agency is Lead Agency for California Small County Collaborative (CSCC)

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Part I - Background (continued)

Common Components across ALL Counties (Mariposa, Plumas and San Benito)

- Automated Client Data Management & Care Coordination System
- Participant “Client” engagement
- Comprehensive Care Coordination (CCC)
- Data Collection and Reporting
- Universal and Variant Metrics
- Centralized Financial Claiming and Data Reporting to Department of Health Care Services (DHCS)

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Part II – Section 1:

WPC County Lead Entity and Participating Entity Information

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

County Lead Entity

- ***Small County Whole Person Care Collaborative Executive Committee*** = *Directors from each County*
  1. Participant engagement
  2. CCC Process
  3. Data collection and reporting
  4. Reporting metrics (Universal + Variant)
  5. Fiscal claiming to DHCS for WPC reimbursement

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

County Lead Entity (continued)

- ***Individual County WPC Collaborative Leadership Committee*** *= HHS + Participating Entities (PEs)*
  1. Identification of the target population(s) and timely assessment of their needs;
  2. Assurance of local collaboration and programmatic coordination across all PEs;
  3. Ongoing facilitation of care coordination among service providers;
  4. Development of an appropriate and effective strategy for sharing confidential data among PEs that supports identification of common clients, coordination of care, improved access to needed services, and data collection and reporting

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participating Entities

1. Managed Care Health Plans
   - Anthem Blue Cross for Medi-Cal Managed Care – Janet Pain
2. Public Agencies
   - SBC HHSA = Lead Entity
   - SBC Public Health Department (SBCPH) – Lynn Mello
   - SBC Human Services Behavioral Health and Recovery Services (SBCBHRS) – Alan Yamamoto
   - San Benito County Probation Department (SBCPD) – R Ted Baraan
   - Santa Cruz Housing Authority (SCHA) – Jenny Panetta

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participating Entities (continued)

3. Community Partners (CPs)
   - CP 1: Public Agency – SBC Community Services and Workforce Development Division (SBCCSWD) - Enrique Arreola
   - CP 2: Hazel Hawkins Memorial Hospital (HHH) - Ken Underwood
   - CP 3: San Benito Health Foundation (SBHF) – Rosa Vivian Fernandez
   - CP 4: Coalition of Homeless Providers aka Continuum of Care (COC) - Katherine Thoeni
   - CP 5: Youth Alliance - Diane Ortiz

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Part II – Section 2:

General Information and Target Population

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Geographic Area, Community, and Target Population Needs

2013 HUD Point in Time Homeless Count	277 persons
2015 HUD Point in Time Homeless Count	651 persons
2017 HUD Point in Time Homeless Count	?

Medi-Cal Anthem Blue Cross	7,673
Fee for Service	11,350
Total Medi-Cal - DHCS	19,023

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Vision and Structure of WPC Pilot

- BOS formed Homeless Planning Committee/Collaborative in 2008
- State of CA Community Development Block Grant ($1.5 million) for Homeless Shelter
  - Phase One: 4,300 square foot Homeless Shelter – December 2017
  - Phase Two: WPC space and other supporting services
- “Helping Hands” rental assistance
- Tenant Based Rental Housing (TBRA) using Federal Home Funds

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Pilot Strategy

- Care Coordination and Alignment with Current System:
  - Participant Engagement
  - Comprehensive Care Coordination (CCC)
  - Housing Placement

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Pilot Strategy (continued)

- Build upon and strengthen existing efforts in the community
  1. Health care
  2. Education
  3. Housing
  4. Jobs

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Sustaining WPC - Goals

- Reduced inpatient hospitalizations
- Reduced rates of chronic health problems
- Reduced Emergency Department use
- Reduced interaction with law enforcement and the justice system
- Automated Client Data Management System
- Reduced costs

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Communication Plan

- Executive Committee will serve as policy making body – *meets monthly*
- HHSA LE will work with other PEs = Homeless Planning Collaborative = Department Heads, upper management, community partners, non-profits and local residents.
- WPC Leadership Committee – *meet weekly to monthly*

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

WPC Leadership Committee Objectives Y1 & Y2

- WPC baseline data gathering and analysis
- WPC program planning and policy development
- Review and finalize infrastructure needs
- Metrics and evaluation framing
- Developing housing support relationships
- Comprehensive systems mapping
- Focused implementation planning and objectives and activities

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

WPC Leadership Committee Objectives Y3 to Y5

- Review metrics and evaluation of findings
- Use evaluation findings for improvements
- Services monitoring
- Services coordination
- Health outcomes
- Housing support outcomes
- Adopt WPC sustainability plan

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Target Population

- Individuals, ages 18 to 64, who are homeless or at risk for homelessness and one or more of the following:
  - Have behavioral health condition (mental health, substance abuse, or co-occurring diagnosis)
  - Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement
  - Two or more chronic conditions
  - Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

WPC 5-Year Projects Target Population

Target Populations	PY 2	PY 3	PY 4	PY 5	Totals
Homeless/At Risk of Homelessness	22	45	25	15	107
High Medi-Cal Users	5	5	5	5	20
SMI/SUD	5	5	5	5	20
High Hospital ER Inpatient Utilization	5	5	5	5	20
Criminal Justice Population	5	5	5	5	20
Totals	42	65	45	35	187
Note: No enrollment cap					

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Part II – Section 3:

Services, Interventions, Care Coordination and Data Sharing

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Services, Interventions and Care Coordination

- Participant Engagement and Outreach at “street level”
- Comprehensive Care Coordination through CCC Team and CCC Plan
- Housing Navigation

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Engagement Team (PET)

- Assessment Coordinator
- Community Health Nurse
- Probation Officer
- Peer Advocate

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Engagement and Outreach

- Community outreach by PET. Screen individuals for appropriate referrals to WPC or other programs including PRIME.
- Referrals to PET from:
  - HHH
  - SBHF, Anthem and other health providers
  - County BH, PH, probation, social services
  - Associated non-profits
  - Local housing agencies

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Engagement and Outreach (continued)

- PET will venture into business and residential neighborhoods where there are known concentrations of homeless.
- The PET will assist with:
  - Comprehensive Care Coordination Plan (CCCP)
  - Making appointments with health care providers
  - Travel to attend appointments and receive services
  - Applications and processing for public benefits.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Engagement and Outreach (continued)

- 50 potential enrollees annually
- Length of engagement services will average 2 months with a range of 1 to 4 months
- PET will hand off to Lead Care Coordinator focus will shift to Comprehensive Care Coordination

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Comprehensive Care Coordination Team (CCCT)

- Lead Care Coordinator
- Community Health Nurse
- Mental Health Clinician
- Substance Abuse Recovery Specialist
- Peer advocate
- Housing Navigator, as appropriate

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Comprehensive Care Coordination

- CCCT will conduct full assessments of health, mental health, substance abuse and housing needs.
- Develop tailored CCC Plan for each participant
- CCCT members will be assigned responsibilities based on the needs of the participant
- Participant has regular meetings with CCCT
- CCC will conclude when individuals “graduate” upon completion of their CCCP goals

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Comprehensive Care Coordination (continued)

- CCCT will will provide care coordination services at a high level of intensity; “whatever it takes” to support the participant in achieving their recovery goals.
- 24/7/365 access to services and commitment to engage and collaborate with any potential sources of support to the participant, including friends, family, medical providers, pets, treatment providers and a probation officer.
- CCC will be conducted with 107 potential WPC participants over the life of the Project and the length of CCC will last from 3 to 12 months with an average of 6.75 months per participant for a total of 722 member months

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Housing Navigation and Supports

- Assessment of eligibility for various housing supports;
- Assisting individuals to search for housing;
- Breaking down barriers associated with obtaining housing;
- Helping with credit repair or criminal record expungement;
- Providing advocacy with landlords; and
- Helping participants to build the skills and supports necessary to maintaining housing over time.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Housing Navigation and Supports (continued)

- Participants enrolled in CCC who are determined to be homeless or have unstable housing/imminent risk of homelessness, will be linked to the Housing Navigator.
- Housing Navigator works with the CCCT to ensure housing goals are included in the CCCP and there is a seamless coordination of services.
- Once the goals/activities of this service are complete, the Housing Navigator will inform the lead staff, which will trigger a “graduation” from Housing Navigation and Supports Bundle.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Housing Navigation and Supports (continued)

- Housing services will include:
  - Housing assessment and individualized housing support plan,
  - Assisting with housing applications
  - Identifying and securing available resources to assist with available housing subsidies especially the project based voucher program offered by our participating entity, the Santa Cruz Housing Authority.
  - Support for security deposits, moving costs, utility service issues, furnishings, and disability modifications.
  - Monitoring placements to be ready to mediate with landlord problems or possible terminations of tenancy.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Additional Services

- Job Skills and Pre-employment Training – SBCCSWD
- Medical Respite Plan with HHH
- Probation Department to identify individuals who are within 90 days of release from jail and meet WPC enrollment criteria, including crisis and/or hospitalizations, chronic health conditions and homeless or at risk upon discharge.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Data Sharing

- Develop automated Client Data Management System) – CIBHS for eBHS

- The purpose is to provide an automated system with bi-directional capabilities for use by the Lead Case Manager, the CCC Team, and other selected users determined by the county, including hospitals, other health and behavioral health care providers, and community-based service providers.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Data Sharing (continued)

Aggregate and integrate relevant target population data in the following manner:

- Incorporate and map data across multiple systems, including Medi-Cal Managed Care Plans, the Medi-Cal Fee For Service program, hospitals, differing local EHR systems, County Behavioral Health, and community-based providers;
- Provides integrated data at the individual WPC participant level by creating a profile of each participant's overall utilization of services across multiple systems;
- Incorporates and captures diagnostic information to assist in identifying WPC participants with multiple conditions, including those with behavioral health conditions;
- Incorporates and captures non-health care data, including data on housing instability, homelessness and interaction with the justice system;

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Data Sharing (continued)

Aggregate and integrate relevant target population data in the following manner (continued):

- Provides a mechanism for managing Comprehensive Care Coordination services provided to WPC participants, documenting services, and monitoring participant progress;
- Updates data at periodic intervals to capture all utilization and service data for WPC participants over time, including when possible, periods of prior services utilization; and,
- Provides for WPC participant-level and WPC population-level data reporting so that changes and progress for individuals and populations can be monitored, evaluated, documented and Plan-Do-Study-Act processes can be implemented.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Part II – Section 4:

Performance Measures, Data Collection, Quality Improvement and Ongoing Monitoring

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Performance Measures

- Collect data to assess each Participating Entity and contracting service provider including CCC plan and utilization data.

- Each person referred for CCC will receive screening and assessment including PHQ-9, suicide tool and VISPDAT

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Performance Measures (continued)

- Service utilization data will include:
  - Comprehensive Care Coordination
  - Support services such as housing and job skills
  - Emergency Department and acute inpatient hospital services
  - Primary and specialty care
  - Psychiatric hospital services, mental health outpatient, and substance use treatment services

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Performance Measures (continued)

Client Data Management System, ***eBHS,*** will provide documentation of:

- Number of clients served each month
- Specific services provided
- Assessment findings
- Associated outcomes.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Performance Measures (continued)

eBHS data will be used by *WPC Leadership Committee* to monitor the effectiveness of the interventions, including:

- Improvements in housing stability and changes in participant use of Emergency Departments
- Acute inpatient hospitalization and psychiatric inpatient utilization
- Effectiveness of services and costs and continuing barriers to effective service delivery
- Guide its Plan-Do-Study-Act (PDSA) process.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Universal Metrics

Health Outcomes

1. Ambulatory Care – Reduce ED use
2. Inpatient Utilization-General Hospital/Acute Care (IPU) – Reduce inpatient utilization as part of CCC
3. Follow-up After Hospitalization for Mental Illness (FUH) – Percent of participants receive follow-up within 30 days after hospitalization
4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiate and Engage with participants with identified treatment need

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Universal Metrics (continued)

Administrative

5. CCC Plan – Participants with a CCCP within 30 days of enrollment and annual re-assessment with updated tailored plan

6. Care Coordination, Case Management and Referral Infrastructure – Develop shared policies and procedures, review semi-annually and utilize the PDSA model to modify and implement change across entities

7. Data and information sharing – Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC collaborative, county pilot leads and all participating entities

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Variant Metrics

VM1: Implement VISPDAT for WPC participants

VM2: 30 Day All Cause Readmissions

VM3: PHQ-9

VM4: Suicide Risk Assessment (C-SSRS Tool)

VM5: Housing Services

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Data Analysis, Reporting, and Quality Improvement

Key Data

- Demographic information
- Source of referral
- Timeframe for response to referral
- Timeframe for CCC Plan development
- Documentation of all services provided to participant

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Data Analysis, Reporting, and Quality Improvement (continued)

- Prior to CCC Plan, participants to sign:
  - Universal Release of Information (ROI)
  - Informed Consent
- Data Sharing and Privacy Agreements signed with all PEs.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Quality Improvement Outcome Measures

- Reduction in ED visits
- Reduction in acute inpatient and psychiatric inpatient hospitalizations
- Housing stability
- Regular use of primary care services
- Improvements in participant reported health and mental health status

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Plan-Do-Study-Act (PDSA)

Facilitates Quality Improvement by:

- Identifying the aim to be achieved;
- Describing the measurable outcomes to be achieved toward that aim;
- Defining the processes currently in place; identifying opportunities for improvement; and, determining necessary changes to the intervention based on analysis.
- The Plan-Do-Study-Act Cycle will be included at multiple points during Project implementation and throughout the life of the Project.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Plan-Do-Study-Act (PDSA) (continued)

Focus on three questions for improvement:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Plan-Do-Study-Act (PDSA) (continued)

- **Monthly**, used by CCCT and PET to assist with improving outreach and coordination
- **Quarterly**, used by WPC Participant Entities

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Plan-Do-Study-Act (PDSA) (continued)

System level use:

- Development and implementation of engagement strategies
- Screening tools
- Care Plan documents
- Data collection tools
- Data entry processes
- Report development
- Service and support implementation
- Housing navigation strategies

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Plan-Do-Study-Act (PDSA) (continued)

Individual or case level use:

- During CCCT and participant meetings on how they are progressing towards meeting their goals.
- There will be discussions and assessments about which factors in their lives are helping them and which are hindering them from making meaningful changes or progress

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Entity Monitoring

- All Participating Entities enter into an MOU with Lead Agency (HHSA)
- Quarterly program and financial monitoring
- Site visits may include:
  - Review of invoices
  - Employee timesheets
  - Case files
  - Policies and procedures
  - Complaint and incident reports

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Entity Monitoring (continued)

Program monitoring:

- Accountable for carrying out the agreed-to scopes of services and performance standards;
- Meet service requirements associated with performance metrics specified in the contract;
- Maintain and provide records that accurately reflect whether performance metrics and outcome measures have been achieved or not achieved.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Participant Entity Monitoring (continued)

Financial monitoring:

- Funding has been used for allowable and budgeted activities;
- Expenditures are supported with proper documentation, and financial records are maintained that provide an appropriate audit trail
- Payment to Participating Entity or Contract do not exceed the contract maximum without appropriate amendment
- Contractor has appropriately complied with all applicable federal, state and county contract laws and regulations.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Part II – Section 5:

Financing

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Financing Structure

Budget in 6 main categories

1. Administrative Infrastructure
2. Delivery Infrastructure
3. Incentives
4. PMPM Bundles
5. Fee-for-Services
6. Pay for Outcomes

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Administrative Infrastructure

Covers the following:

- Deputy Director
- Fiscal Support
- Contractor
- Travel
- Office space
- Training

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Delivery Infrastructure

Covers the following:

- Communication
- Computers
- Copier/printer/scanner
- Van

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Incentives

Covers the following:

- $75.00 paid to each health care provider when participant is enrolled in CCC
- $600/month to HHH for reporting WPC participants in ED

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

PMPM Bundles

1. Comprehensive Care Coordination (CCC)

2. Housing Navigation and Services

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

PMPM Bundles (continued)

CCC Bundle covers:

- Program Manager
- Office Assistant III
- Social Worker I
- Peer Advocate
- Community Health Nurse
- Mental Health Clinician
- Substance Abuse Specialist

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

PMPM Bundles (continued)

Housing and Support Services Bundle covers:

- Program Manager
- Office Assistant III
- Housing Navigator/Tenancy Care Support

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Fee-For-Service

For Engagement and Outreach

- Program Manager
- Office Assistant III
- Social Worker I
- Peer Advocate
- Community Health Nurse
- Probation Officer

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Pay for Outcomes

Anticipated 5% reduction annually in Emergency Department utilization and hospital admissions.

To be paid Program Year (PY) 2-5 to HHH

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Budget Summary

PY 1	$500,000
PY 2	$500,000
PY 3	$1,000,000
PY 4	$1,000,000
PY 5	$1,000,000
Total	$4,000,000

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative