Whole Person Care Promising Practices:

A Roadmap for Enhanced Care Management and In Lieu of Services

December 2020

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Introduction

California's Department of Health Care Services (DHCS) established the Whole Person Care (WPC) Pilot Program through its Medi-Cal 2020 Section 1115 waiver, effective January 1, 2016 – December 31, 2020[1], with the goal of better coordinating health, behavioral health, and social services in a "whole person" approach for Medi-Cal beneficiaries who are high users of multiple health care systems and have poor health outcomes. DHCS approved 25 pilots across the state, designed and led at the local level by counties, public hospital systems, and cities, to develop infrastructure and provide 'whole person care' services to high utilizers of multiple systems.

All pilots were required to participate in a WPC Learning Collaborative for the duration of the waiver to ensure pilots had an outlet to share and discuss challenges and successes as they implemented their innovative and complex programs. The Learning Collaborative brought pilots together both virtually and in-person through calls, webinars, and day-long convenings.

As part of the WPC Learning Collaborative, pilots were asked to document lessons learned through the Promising Practices Project (PPP), which began in 2019. The goal of the project is to prepare pilots to sustain the most valuable aspects of their pilots after the waiver expired on December 31, 2020 (see foot note below). By memorializing the most successful practices, including the implementation process and results, pilots created shareable materials that demonstrated the value of services provided through WPC.

In October 2019, DHCS announced the California Advancing and Innovating Medi-Cal (CalAIM) initiative that outlined the path forward for WPC pilots once the Whole Person Care Pilots end. Key components of the CalAIM initiative build upon the experiences of WPC—the Enhanced Care Management (ECM) benefit and In Lieu of Services (ILOS) menu in particular. Under CalAIM, ECM and ILOS are both the responsibility of Medi-Cal managed care plans (MCPs). Because MCPs generally have limited experience with WPC and were not the lead entities responsible for developing and implementing the pilots, the WPC Promising Practices can provide MCPs with clear examples of the services provided under WPC, the steps they took to implement, and the results they have generated thus far.

Although the CalAIM initiative, including the implementation of the ECM benefit and ILOS, has been delayed due to the impact of the COVID-19 public health emergency, it remains a priority of the Department. While WPC will likely be extended through December 2021, preparing for the eventual implementation of ECM and ILOS by learning from the WPC pilots' experience is important for a smooth and informed transition.

This paper summarizes WPC Promising Practices and crosswalks them to the ECM benefit and ILOS menu proposed under CalAIM. MCPs, counties without WPC experience, and other

[1] DHCS submitted a request to extend the Medi-Cal 2020 Section 1115 waiver through December 31, 2021 to the Centers for Medicare and Medicaid Services (CMS). If the waiver extension is approved, Whole Person Care will continue through December 2021.

interested stakeholders should read the summarized Promising Practices below to inform the successful implementation of ECM and ILOS under CalAIM.

Promising Practices Related to Enhanced Care Management

The following Promising Practices should be considered in the context of the ECM benefit proposed under CalAIM. The ECM benefit will provide a whole-person, collaborative, and interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in managed care.

ECM services include:

- Helping beneficiaries navigate, connect to and communicate with providers and social service systems;
- Coaching beneficiaries on how to monitor their health, and identify and access helpful resources;
- Identifying and coordinating in lieu of services;
- Helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions;
- Educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; and
- Providing referrals to community and social services and follow-up to help ensure that beneficiaries are connected to the services they need.

The following WPC Promising Practices related to ECM are divided into two categories: 1) Outreach and Engagement and 2) Care Coordination.

Outreach and Engagement

Alameda County: Consumer and Family Fellowship

Description: The Consumer and Family Fellowship is a skills-building and leadership development experience for consumers and family members of consumers who want to learn how to navigate Alameda County's public systems.

Program fellows develop a deep understanding of the health care system in cohorts and advise leadership on projects to improve the consumer experience. Each month builds upon competencies developed in the previous month. Fellows are mentored by professional staff, supported by peers, and compensated in recognition of their time, commitment, and expertise. Fellows are expected to spend 10 hours per month on Fellowship activities, including:

- Monthly workshops – training and skills development with cohort members
- Fieldwork and service projects – speaking at community events
- Tool development associated with county projects

Findings: The Fellowship offers further learning for consumers and family members with lived experiences who are already leaders within their communities and enables the County to learn

from the consumers' expertise, needs, and preferences and build this important feedback into the design and implementation of services.

The Fellows develop leadership skills, acquire knowledge of the County's public services, earn money, and learn about new projects and resources that they can take back to their community organizations.

Alameda County: Information Sharing Authorization

Description: Information Sharing Authorization is an electronic and paper form that accompanies and supports the use of the Community Health Record (CHR)/Social Health Information Exchange (SHIE).

The Information Sharing Authorization allows WPC consumers to choose whether to have their information (beyond that which is sharable without authorization per State and Federal laws) accessible through the SHIE. When executed, the WPC client authorizes (via signature) Alameda's Health Care Services Agency to share medical, mental health, housing, social services, and jail health information with and between CHR/SHIE partners to support better coordination and improve the health care experience. The form includes specific permission for sensitive services (i.e., HIV and mental health treatment), but does not include the sharing of substance use treatment information protected by Federal law 42 C.F.R. Part 2. The form is valid for one year and can be modified or revoked at any time by the client.

With consumer authorization, information from programs and services the consumer has received in the past, currently receives, and may receive in the future can be shared. The shared information may include:

- Consumer name, address, date of birth, etc.;
- Status of medical or mental health and related treatments;
- Housing, food, transportation, employment, income, and disability needs; and
- Support the consumer receives through the county Social Services Agency including Medi-Cal, CalFresh, General Assistance, CalWORKs, and Supplemental Security Income.

Contra Costa County: Automating WPC Client Enrollment

Description: Using a predictive risk model, Contra Costa's WPC program can automatically identify eligible Medi-Cal individuals at risk for future avoidable emergency department or inpatient utilization. Each month, eligible individuals are flagged for enrollment based on the number of available spots in the pilot. Upon enrollment, individuals are automatically assigned to a 'best fit' case manager based on elements available in the health record and data warehouse, including past utilization, diagnosis, language, and geographic region. The entire process is automated, from identifying high-risk individuals, to assigning a case manager, to mailing an introductory welcome letter. Utilizing data to drive automation allows for scalability. The risk model continues to evolve with additional data elements added as information becomes available, expanding its ability to predict future utilization.

Findings: Contra Costa's data-driven automation has enabled enrollment of 50,000 individuals into the WPC pilot to date and is estimated to save nearly 350 administrative hours per month.

Contra Costa County: Universal Social Needs Screening

Description: Contra Costa's WPC pilot developed a population-wide social needs screening tool to screen new enrollees for unmet social, medical, and behavioral health needs. Case managers developed the screening tool internally using Plan-Do-Study-Act cycles to optimize question-wording, order, and delivery across ten social domains. The final version of the tool includes 42 questions covering transportation, finances, food security, education, housing, legal, social support, safety, medical, dental, vision, and behavioral health.

Case managers use the tool during their first or second meeting with an enrollee to build rapport and identify areas of unmet need. Each screening ends with the case manager asking the patient what is most important to them and what they would like to work on. The results of the screening directly inform the enrollee's care plan. The tool, screening results, and care plan are embedded in the EHR and are available to care team members.

Findings: Between June 2018 and February 2019, Contra Costa's WPC pilot screened over 12,000 enrollees using the new screening tool. Case managers report positive feedback on the tool's ability to help them engage clients, identify unmet needs, and set the stage for ongoing care planning. As the county looks to expand best practices from the pilot to the larger health system, it is considering condensing the tool to enable screening in other settings.

Contra Costa County: Providing Smart Phones to WPC Enrollees

Description: Contra Costa County's WPC pilot developed a partnership with Sprint to provide cell phones to enrollees. Through the partnership, Sprint charges the county a negotiated monthly service fee of $12 per phone line and provides free refurbished smartphones. The contract includes 2GB of data and unlimited text/voice service for each phone. The county pre-loads the phone with apps related to transportation, health, mindfulness, and social services including myBenefits and CalWIN. Case managers identify enrollees likely to benefit from a smartphone and those enrollees receive the phone free of charge for a period of time during program enrollment. After that time expires, case managers work with enrollees to transition them to a phone plan.

Findings: Between October 2018 and November 2020, the county has issued 2581 cell phones to 1,735 unique clients (828 enrollees have needed replacement phones). Case managers report that phones increase engagement in services and make it easier to get in touch with clients to schedule visits. Available usage data reveals high rates of talk, text, and data consumption. These high usage rates are encouraging and may be useful to the county as it explores additional mediums for bulk outreach. Transitions to longer-term plans not managed by the WPC program have only recently begun so the success and future challenges of this area remain unknown.

Kings County: Flexible Service Delivery

Description: Flexible Service Delivery enables clients to drop-in for doctor visits and staff to meet clients where they are. This model reduces barriers to care, improves engagement, and increases enrollment in WPC. WPC partners refer clients for immediate screenings which the WPC team can provide quickly due to Flexible Service Delivery. The WPC team, which includes a Public Health Community Health Aide, Human Services Eligibility Worker, and a Mental Health Screener, sees potential WPC enrollees with little to no wait time, thereby taking full advantage of their time with each client.

Findings: Flexible Service Delivery improves the ability of case managers to help enrollees access needed services and resources. In addition, enrollment into WPC doubled after implementation and the number of individuals who were unable to be reached following referral decreased by 32%.

San Diego County: Transfer of Care Team

Description: San Diego's WPC pilot initially found it difficult to identify and locate individuals that met program criteria and would benefit from WPC services. Referrals were often submitted with incomplete information and at inappropriate times (such as upon discharge from the hospital, etc.), making it difficult to determine Medi-Cal eligibility and to outreach to potential enrollees while they are in the hospital.

To address this challenge, the county established a key contact for each referring entity to improve the quality of referrals and the ability of the WPC provider to respond quickly. Hospitals have multiple departments that provide case management and referrals and designating a key contact creates a system that ensures each potential WPC enrollee is screened for eligibility. In addition, the key contact serves as a WPC liaison within their organization.

Findings: During 2018 there were 44 unduplicated referrals to WPC from the hospital's transfer of care department Among the 44 individuals who were referred to WPC through this system in 2018, there were a 41.3 percent decrease in emergency department admissions and inpatient hospital discharges in the 90 days following entrance into WPC as compared to the 90 days before entering WPC.

Care Coordination

Alameda County: Care Community Case Conferencing

Description: Alameda County has a regionally-focused Care Community of client-facing care coordination, housing navigation, and care management staff and their supervisors that serve a shared set of consumers and meet regularly in a case-conferencing setting to address challenges facing those consumers.

By working specifically with client-facing providers, the Care Community cohorts elevate solutions that address chronic issues they experience when serving consumers with complex needs. The collaborative work clarifies processes on how to efficiently access services, build

connections among providers to reduce silos and integrate resources, strengthen capacity to navigate the systems, and address system-level barriers that impede routine consumer-centered care.

To accomplish this work, the county focused on three key areas: training, process change, and relationship building. Elements used to reinforce these key areas are:

- Group Workshops: Collaborative sessions to support the goals of the Care Community;
- Mini-Teaches: Teaching the basics of accessing various parts of the system;
- Care Conferencing: Facilitated peer problem solving of complex cases; and
- One-on-One Staff Support: Regular meetings at the provider site with an assigned WPC staff member and Quality Improvement Coach.

Findings: The first Care Community cohort ran from July to December 2019. Cohort participants were providers who worked with individuals on the housing by-name-list in Oakland. Providers came from housing, primary care, mental health, substance use treatment, and community-based care management entities. Participants in the first cohort noted that it had the following impacts:

- They acquired information and knowledge that enhanced their job or brought them new or refreshed awareness around particular topics;
- They developed a new appreciation for barriers or struggles faced by their clients and other providers;
- The program increased their ability to connect clients to resources through an increased understanding of available services; and
- The program served to fill a significant provider-level training gap.

The second Care Community cohort launched in January 2020 and ran through June 2020. This cohort is focused on frequent visitors to Psychiatric Emergency Services (PES), the county's new Community Health Record, and a resource-sharing tool called Elemeno. This Care Community included a monthly check-in with an executive-level staff member so they could disseminate learnings and embed Promising Practices into regular workflows.

Alameda County: Cross-Sector Workforce Development

Description: The Alameda County WPC pilot has invested in a Skills Development Unit with partners from the University of California San Francisco Pacific AIDS Education & Training Center and the Community Health Center Network. This county-wide cross-sector training academy focuses on consumer engagement skills and sharing sector-specific knowledge. The goal is to increase WPC staff access to skills development that will improve whole-person care service delivery.

Findings: Over a two year period, 914 unique participants from 97 organizations participated in the Care Connect Academy's 88 trainings. Based on survey responses conducted after each training, the highest-rated trainings were Motivational Interviewing, Public Benefits 101, and Accessing Primary Care 101.

Riverside County: Increasing Medi-Cal Enrollment

Description: In order to increase the number of clients enrolled in Medi-Cal, Riverside WPC staff follow up with individuals within one week of conducting an initial screening to ensure clients are successful in accessing enrollment forms and completing the enrollment process.

Findings: Through this follow-up process, Riverside County's WPC pilot has increased the number of Medi-Cal enrollments for those who qualify from less than 10% to over 80%. Clients have expressed appreciation that pilot staff cares about them. As a result of this practice, silos have been broken down within the county and the increased collaboration has improved care coordination, sharing of resources, and reduced duplication of efforts, all while maintaining a focus on what is best for the client.

San Bernardino County: WPC Accountability Review (WAR) Conference

Description: The San Bernardino WPC pilot conducts WAR conferences once a month for all interdisciplinary care teams. The meetings are an opportunity to review and discuss the status of each enrolled client. Each team discusses the following questions to assess their performance concerning the pilot and client's goals:

- Are we reaching the target population (high utilizers with two or more chronic conditions)?
- Are we continuing to engage the client?
- When was a client's last face-to-face encounter?
    - If it has been a while:
        - Did the client move?
        - Is the client non-compliant?
- What services does the client need?
- Do clients need an RN, social worker, and/or alcohol and drug services?
- What are the results of the Patient Activation Measure survey, PHQ-9, and/or suicide assessment?
- How long has the client been enrolled in WPC?
- Have the client's health outcomes improved?

Findings: As a whole, the San Bernardino pilot tracked positive outcomes, some of which can be attributed to WAR Conferences (through July 2019):

- Overall Health (self-reported): 510% improvement from 2017
- Overall Mental Health (self-reported): 366% improvement from 2017
- Blood pressure age 18-59 (PB <140/90) 80% now under control
- Diabetes Care (under control): 20% increase from 2017
- Suicide Risk Assessment: 610% improvement from 2017
- All-Cause Readmission: 6% decrease in admissions from 2017
- Inappropriate ED Visits: 86% decrease in admissions from 2017
- Inappropriate inpatient Utilization: 77% decrease in utilization from 2017

- 7-day follow-up after hospitalization for mental health: 48% improvement from 2017
- 30-day follow-up after hospitalization: 7% increase in follow-ups from 2017

San Diego County: Case Conferencing

Description: Given the complexity of needs experienced by the WPC population, coordinated care between health plans and San Diego County is critical. Lack of coordination between WPC and the health plan's complex case management teams results in fragmented care and increases inefficiencies. Additionally, those engaged in advocating and providing care for the population are constantly working in the community, making communication for the purposes of care coordination across entities difficult.

San Diego created standing meetings between appropriate representatives from health plans and the WPC team, which enables the development of a coordinated care plan and leverages the resources of both entities efficiently and effectively. The standing meeting reduces the amount of time each entity spends trying to contact with one another about program enrollees. Additionally, if an enrollee needs urgent attention before a scheduled meeting, both entities are familiar with the enrollee's background, enabling quicker problem resolution.

Findings: Though San Diego has seven Medi-Cal health plans involved with WPC, only one of the larger health plans initiated weekly 30-minute case conferencing meetings with WPC to coordinate care and identify participants for the program. This practice established a more efficient way of coordinating care, reducing the number of phone calls and messages between entities. It also helped to build relationships between the partners and streamlined service delivery when urgent needs arise.

Twenty-nine percent of WPC enrollees originated from the one health plan initiating this practice.

Ventura County: Community Health/Service Worker Training and Support

Description: Very few staff hired to provide support services to WPC patients are equipped at the outset with the skills required to serve a high-complexity, high-need population in the innovative setting of WPC. Challenges arise when new staff come on board at different times and rely solely on learning by doing.

Rigorous training and ongoing reinforcement and support through a daily huddle prepare staff to safely, appropriately, and effectively address challenging situations as they arise in the field. A well-trained and supported team will promote safety for both the team and patient, experience less secondary stress and burnout, and achieve better outcomes.

Regular staff trainings on a variety of topics relevant to WPC reinforced by just-in-time support from a daily huddle prepare staff for nearly any situation they face in the field.

Findings: A well-trained and supported team has a direct impact on the lives of patients and the program's outcomes. Outcomes achieved include:

- Emergency Department Utilization: 73% reduction from baseline
- Inpatient Utilization: 47% reduction from baseline
- All Cause Readmissions: 58% reduction from baseline
- Recuperative Care Readmissions: 11% improvement over baseline
- Hypertension: 250% improvement over baseline
- Follow-Up after Hospitalization for Mental Illness at 7 days: 47% improvement over baseline; at 30 days: 27% improvement over baseline
- Initiation of Alcohol and Drug Treatment at 14 days: 92% improvement over baseline; at 30 days: 9% improvement over baseline
- Housing Services: 72.5% of enrollees connected to services

Promising Practices Related to In Lieu of Services

The following summaries are Promising Practices from WPC pilots that can be considered in the context of the ILOS menu proposed under the CalAIM initiative. Services provided under ILOS are flexible wrap-around services that can be provided to members 'in lieu of' a more costly and intensive service. Managed-care plans have the option of offering ILOS and members have the option of accepting them. ILOS can be combined with new or existing care management services. The proposed CalAIM ILOS include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF)
- Nursing Facility Transition to a Home
- Personal Care (beyond In-Home Services and Supports) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers

Through WPC, multiple counties piloted innovations focused on individuals experiencing homelessness. The following Promising Practices are examples of components that can be considered either as a direct ILOS or to support the delivery of an ILOS. Some services under ILOS may also be provided in coordination with the ECM benefit, so the following Promising Practices could also be useful to consider in that context. The following WPC Promising Practices specifically correlate to the following proposed ILOS:

- *Housing transition navigation services* assist beneficiaries with obtaining housing and should be based on an individualized assessment of needs and documented in the individualized housing support plan.
- *Housing deposits* assist with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board.
- *Housing tenancy and sustaining services* are used to meet the goal of maintaining safe and stable tenancy once housing is secured.
- *Recuperative care* is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.
- *Sobering centers* are a safe, supportive environment for individuals who are homeless or have unstable living situations and are found to be publicly-intoxicated to become sober as an alternative to the ED or jail.

Housing Transition Navigation Services

Alameda County: Homelessness Transition Services - Safe Parking Program

Description: The Alameda County Safe Parking Program provides safe overnight parking for individuals who find themselves living in their vehicles. The program includes portable toilets, hand washing stations, evening security, and access to staff who can connect participants to other county services.

By creating a safe place to park, participants can focus on building the skills needed to be successful in housing, including the ability to interact and work with neighbors and community institutions. Alameda County Safe Parking focuses on developing community leadership and self-governance structures, including: (1) problem solving and conflict mediation between participants, (2) identifying mentorship opportunities, (3) individualized goal setting as a part of identifying the unique challenges, traumas, and resilience factors of each participant, and (4) pairing participants with necessary services that will help them transition to housing. Participants also receive post-housing checkups to ensure that they are adjusting well and being connected to other needed services.

Findings: Alameda County Safe Parking deployed clear policies and procedures for data collection along with metrics for measuring successes and areas of opportunity. Information tracked includes safe parker intake, progress, vacancy, and the disposition of safe parkers from the time of enrollment to the time of discharge from the site. Over time, the Safe Parking Program has improved on this process to better:

- Assess project goals;
- Develop strategic and operational measures of success;
- Design in-person and online collaboration tools;
- Develop techniques for project tracking; and

- Promote better inter-city and interagency information sharing, especially around best practices and success stories.

Providing and connecting individuals to wrap-around services and access to housing is a core part of the Alameda County Safe Parking Program's work. The combination of community development and information collection and tracking has enabled the pilot program to better identify partners that can help tackle the unique challenges of participants.

City of Sacramento: Aligning and Co-Locating WPC Services with a Low-Barrier Shelter Approach

Description: In December 2017, the City of Sacramento launched a 200-bed co-ed, low-barrier rehousing shelter that accommodates guests, their possessions, and their pets to increase multidisciplinary providers' ability to address the needs of high-risk, vulnerable individuals, stabilize them, and connect them to permanent housing.

In the month leading up to the shelter opening, community health workers worked with the police department to identify vulnerable individuals at local encampments who qualified for both the shelter and WPC. Once the shelter opened, WPC service providers serve enrollees onsite, provide housing services, and connect individuals to health care and social services.

Findings: Since opening its doors the City of Sacramento's low-barrier rehousing shelter has served 658 guests. Most guests were previously residing in encampments within a mile of the shelter site. The guests generally represent a highly vulnerable population with complex service needs, many of whom had been previously disconnected from services. According to the Sacramento Homeless Management Information System (HMIS) records, for many shelter guests the rehousing shelter was the first homeless program they ever connected with. About half of the guests served in the rehousing shelter enrolled in WPC, and nearly all shelter guests engaged in onsite case management services.

Contra Costa County: Providing Transportation to Non-Medical Appointments

Description: The rising cost of housing in Contra Costa County has forced people to move farther away from the services they need, thus making services less accessible. Because of these geographic and economic barriers, 37% of WPC clients in Contra Costa County have stated they need assistance with transportation.

To address this issue, Contra Costa's WPC pilot contracted with Roundtrip Health, a transportation booking platform, to provide electronic ride-booking and ridesharing services to clients. Roundtrip works within the EHR and allows case managers to dispatch transportation via taxis and rideshare offers. It also offers 24/7 call center support, simplified administration, and real-time data on ride volume and completion rates. Roundtrip services began in Spring 2019 as a small pilot with ten staff members dedicated to providing transportation for WPC recipients and rolled out to all staff in June.

Findings: Between March 2019 and November 2020, Contra Costa County WPC has provided over 16,000 rides through their partnership with Roundtrip with an average ride completion rate of 82.7%. Additionally, high client ratings (average 4.6/5) have encouraged other departments within the health system, including the Medi-Cal health plan, to consider a similar approach to transportation services. Case managers report that providing rides to non-medical appointments has been a key factor in addressing unmet social needs.

San Francisco: Housing Navigation for High Need Homeless Adults

Description: San Francisco used WPC to hire dedicated Housing Navigators to connect with clients as soon as they are assessed and prioritized for placement in housing (referred to as being in "Housing Referral Status") and follow them through lease signing. The Housing Navigators have a 1:25 caseload and are field-based and active in locating clients in the community when needed. Housing Navigation staff are trained to use harm reduction, progressive engagements, and motivational interviewing to help engage people and provide flexible supports to move people into housing that meets their needs. Existing Navigation Centers were expanded through WPC to dedicate beds to Housing Referral Status individuals to keep them involved in the housing placement process. Pilot implementation includes a daily coordination of Navigation Center "bed" placements and sharing information about housing navigation with partners across the public health and Homeless Response System.

Findings: The housing placement rate for Housing Referral Status chronically homeless adults increased significantly from 33% in 2014 to 80% in 2019. Over 800 people were placed in housing in the 2014-2017 period. Currently, housing navigators place over 50 Housing Referral Status adults in permanent supportive housing in San Francisco per month.

Housing Deposits

City of Sacramento: One-Time Funds for Housing Location, Stabilization or Retention

Description: The City of Sacramento's WPC pilot created a "one-time" housing fund to remove financial barriers for clients attempting to access housing. WPC providers can access these funds at any point in time to cover housing placement expenses such as application fees, security deposits, first month's rent, and stabilizing or retaining housing through the purchase of furniture and household supplies. Providers are allotted up to $3,000 per enrollee to cover these expenses but are not allowed to pay for ongoing expenses such as utilities and rent (after the first month).

Findings: This one-time, flexible funding has been instrumental in the success of enrollees finding and retaining housing, particularly among Housing Choice Voucher holders. As housing partners work with landlords to rent to individuals experiencing homelessness via the Housing Choice Vouchers, the $3,000 per enrollee is used to cover high-risk security deposits, application fees, purchase of a bed frame, mattress and other household supplies such as toilet

paper, soap, and cookware. By making these funds available, providers are better positioned to swiftly place individuals with little to no income into housing and provide them with the foundational pieces needed to make a house into a long-term home.

Housing Tenancy and Sustaining Services

Contra Costa County: Medical Legal Aid Partnership

Description: Bay Area Legal Aid (BayLegal) partnered with CommunityConnect to address social needs and improve health outcomes for program enrollees. The partnership enables case managers and attorneys to work collaboratively to assist enrollees with public benefits, health care, housing, estate planning, immigration, criminal records, and family law.

Findings: Between July 2017 to February 2020, 384 cases had been opened. The top three legal services areas that BayLegal attorneys assisted clients with were housing (48%), public benefits and income maintenance (26%), and family law for survivors of domestic violence (11%). Within these legal areas, BayLegal attorneys provided 57% of clients with advice and counsel services, 21% with brief services, and represented 20% in court and provided other extensive services. BayLegal achieved favorable outcomes in 69% of the cases from July 2017 through February 2020, 28% ended with mixed results, and 3% ended unfavorably. Successful outcomes have resulted in preventing housing evictions, restoration and backpay of public benefits, and assistance with obtaining necessary restraining orders for victims of domestic violence.

Marin County: Pairing Case Management with Housing Vouchers

Description of Promising Practice: Faced with severe housing shortages and limited opportunities to place WPC enrollees into permanent supportive housing, Marin County dedicated resources to developing relationships and agreements with existing housing voucher programs. Because the WPC population in Marin is individuals with complex medical and behavioral health conditions, voucher programs were initially reluctant to give any of their limited vouchers to individuals who are challenging to successfully house. To address this concern, the Marin pilot develops a modified Assertive Community Treatment (ACT)[2] team dedicated to providing intensive case management to individuals receiving housing vouchers. Through this arrangement, the Marin WPC pilot has dedicated Section 8, Section 811, and Continuum of Care housing vouchers for their clients.

Findings: In the first sixteen months of implementation, the county housed over one-third of the population estimated to be experiencing chronic homelessness in Marin. The preliminary

[2] ACT is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based on the idea that people receive better care when their mental health care providers work together.

analysis demonstrates reductions in utilization among enrollees when comparing baseline data from 2016 with data from the first half of 2018. Data show:

- A 36% reduction of ED visits
- A 44% reduction in the rate of hospitalizations

These early results indicate that WPC enrollment is reducing utilization among high utilizers, though the sample size was small at the point of measurement.

Respite Care

Contra Costa County: Emergency Department and Hospital Post-Discharge Follow-up

Description of Promising Practice: Case managers receive high-risk notifications via the electronic health record (EHR) when a client is discharged from the emergency room or hospital. The notifications are displayed as actionable items on the case managers' workload management dashboard. The high-risk notifications alert case managers to follow up with clients using a high-risk follow-up screening script. The script includes questions about event and diagnosis information, symptoms, medications, and follow-up appointments. Staff is expected to make two telephonic follow-up attempts within the first seven days of the high-risk episode, with further care coordination activities dependent on screening outcomes.

Findings: Between January 2017 and November 2020, Contra Costa's WPC case managers completed 10,688 post-discharge assessments for 4,872 unique clients. In an evaluation of post-discharge follow-ups from January 2017 to February 2020, approximately 29% of individuals received assistance with making a follow-up appointment, 15% received assistance with transportation for an upcoming appointment, and 6% received assistance regarding eligibility or health coverage. Anecdotally, case managers report that the notifications and screening allow for a greater level of care coordination during care transitions and some report that it is useful tool in locating clients that are difficult to engage in case management.

Orange County: Pearl House Behavioral Health Recuperative Care

Description: In February 2019, the homeless population from Santa Ana riverbeds and parks were evacuated into shelters and recuperative care facilities. Orange County Health Care Agency (OCHCA) and its providers noted that certain homeless individuals were exhibiting behavioral health symptoms related to lack of access to medical care, lack of medication, noncompliance with medication, and/or co-existing substance use. Because of unmanaged symptoms, individuals with behavioral health and/or substance use disorder were choosing to leave the shelter or recuperative care center to live on the streets again.

Due to the complexity of the homeless population's needs, including multifaceted mental and physical co-morbidities, Orange County launched a behavioral health-focused recuperative care program. The overarching goal of Pearl House is the successful coordination of medical,

behavioral health, and social services for the population it serves that will result in positive health outcomes, decreased emergency medicine utilization, and opportunities for continued transitional housing.

Findings: With the help of dedicated staff, participants are more likely to be compliant with medications and medical appointments, which is anticipated to lead to more favorable outcomes. In addition, participants are working towards achieving long-term stability and independence, along with aftercare support. Pearl House participants receive targeted services that they otherwise would not have received in a general recuperative care setting. Staff at Pearl House have shared life-changing stories about WPC clients that have passed through their doors.

By more effectively addressing the behavioral health needs of these individuals, Orange County is able to address the acute physical health needs that necessitated recuperative care placement for clients. These clients may not have otherwise received recuperative care services. It is expected that the overall result will be a decrease in the number of times these clients access emergency rooms for treatment and that referrals to recuperative care for this population will be more successful.

San Francisco: Expanded Medical Respite Services

Description: San Francisco operates a medical respite program in partnership with a local community-based organization (Community Awareness and Treatment Services) that operated as a 45-bed facility before WPC implementation. The program originally focused exclusively on providing post-acute recuperative care for people experiencing homelessness who are too sick or frail to be on the streets or in a shelter. In response to advocacy efforts to expand medical respite services to include referrals from the shelter, 30 additional beds were added for clients referred from the shelter. The expanded 75-bed location opened in May 2017 and provides enhanced care coordination and collaboration for these individuals.

Findings: This expansion is the first of its kind in the country and is proving to be an innovative way to address the needs of a highly vulnerable subset of the homeless population, specifically those who are medically ill and may have cognitive and functional impairments as well. Since implementation, the pilot has resulted in:

- Decreased denials of service for a client's inability to self-care or access medically appropriate care;
- Decreased EMS transports and ER visits;
- Decreased burden on shelter staff and management; and
- Increased time for shelter health nurses to focus on population-based care.

In the first year following the opening of Medical Respite expansion, 306 hospital clients and 83 shelter clients were served, with an average length of stay of 39 days for hospital clients and 60 days for shelter clients.

Sobering Center

Santa Clara County: Mission Street Sobering Center

Description: Santa Clara County WPC, led by the Santa Clara Valley Health and Hospital System, opened Mission Street Sobering Center (MSSC) to provide a safe space for clinically intoxicated individuals to recover. The goals of implementing the sobering center are to (1) reduce the expense of incarceration and/or ED utilization; (2) reduce officer time spent on booking this population into jails, and (3) create an opportunity to enroll clients in WPC and connect them to care coordination in addition to a variety of services, assessments, and referrals to treatment.

Mission Street Sobering Center has a clear referral processes and admission criteria. The 24-hour support staff includes individuals with lived experience and nurses to monitor intoxication and withdrawal potential. The sobering center is strategically located across the street from a jail inside the Reentry Resource Center which provides access to social services, a mobile health van, and the Valley Homeless Program. To ensure success of the sobering centers WPC staff meet weekly to assess the program, continue to engage and educate referral partners, and disseminate information sharing protocols.

Findings: Mission Street Sobering Center opened with five chairs and one referral partner and now has 20 chairs and expanded referral sources in addition to law enforcement agencies. Through the implementation of the sobering center the county learned the importance of:

- Engaging referral sources early;
- Engaging and following-up with clients to develop trust;
- Tracking participation;
- Making adjustments as necessary based on demand and available resources.

The characteristics of the 420 total participants (including 36 duplicated participants) to date are:

- 177 self-reported homeless;
- 74 self-reported having a behavioral health diagnosis; and
- 86 self-reported having a medical diagnosis.

Finally, since 2016, the county jail has experienced a 26% decrease in intoxication bookings.

Conclusion

These Promising Practices highlight the varied experiences and learnings of WPC pilots since the beginning of the demonstration period. Each pilot went through extensive trial and error processes to determine what worked best in their region and with their resources. The learnings outlined in this document can serve as a useful roadmap for managed care plans now tasked with sustaining, and in many cases building, similar services under the CalAIM initiative.