Whole Person Care Pilot

Community Connections

A Housing First, Health First Model

About Solano County

- County Population (January 2015): 429,552
- Located approximately 45 miles northeast of San Francisco and 45 miles southwest of Sacramento, the County is bordered by Napa, Yolo, Sacramento and Contra Costa counties.
- The county covers 909.4 square miles, including 84.2 square miles of water area and 675.4 square miles of rural land area

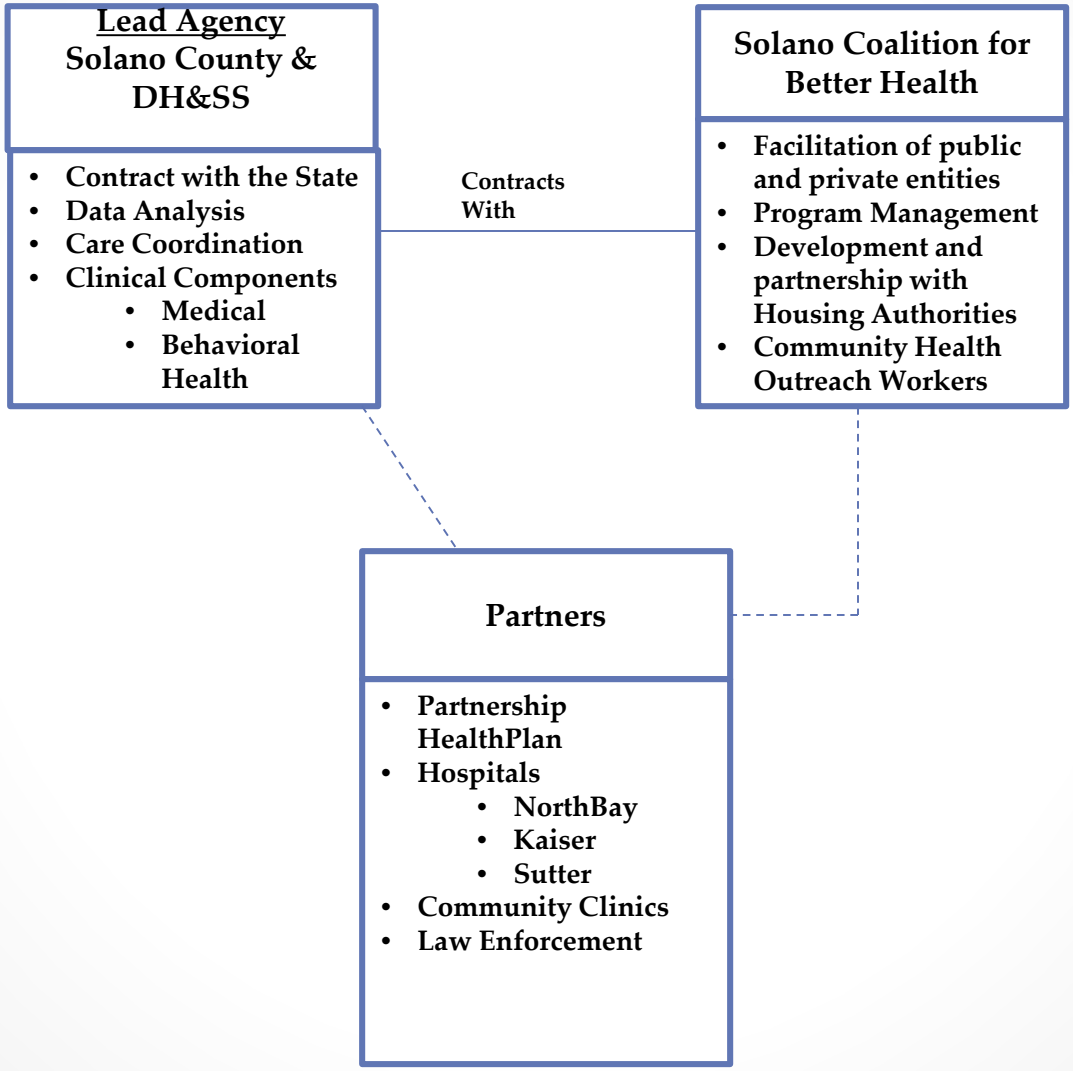
About Solano County

- One of the most diverse communities in California
- Average family income is $67,397 (lowest in Bay Area)
- 48% of families can afford basic living expenses
- 19% of families live in poverty (less than $28,300 for a family of four)

Project Overview

- Solano County H&SS is lead agency
- Solano Coalition for Better Health is the county's sole contracted agency
- Goal of program is to reduce costs and improve health of 300 highest cost Medi-Cal recipients.
- Model is "Housing First/Health First" and is based on "Project 25" in San Diego County.
  - Integrated medical/mental health/substance abuse/dental services
  - Housing services
  - Social determinants of health (Community Health Outreach Workers)

An Integrated Multi-Agency Approach



About the Solano Coalition

- 28-year old agency that started the Partnership Health Plan
- Cooperative organization that includes most WPC partners:
  - County H&SS
  - Local Hospitals and their integrated medical clinics
  - Partnership Health Plan
  - Community clinics (FQHC's)
  - Community Clinic Consortium
  - County Medical Society
- Currently operates a successful respite program for homeless clients discharged from inpatient care.

How Clients are Selected

- High users of medical care per "Top 300" list obtained from Partnership HealthPlan.
- May have housing issues, but not homelessness not required.
- Assigned to the county or unassigned. (year 2)
- Will expand to include , participants who receive primary care from community providers. (years 3-5)
- Hospitals will identify high ED utilizers for prioritization into program.

Our Clients – What we know

- Male in his 50's
- With Expanded Medi-Cal for health insurance but no medical home
- With medical expenses ranging between $400,000 and $500,000
- Flagged for mental health issues and/or substance abuse disorder
- Suffers from hypertension, COPD, or chronic heart failure or some combination of these
- Uses Opioids, with or without a prescription

No current data is available on the housing status of potential clients. Experience to date is that approximately 50% are homeless or at risk for homelessness.

Our Clients – What we know

Range of Costs

- 1 individual with costs of nearly 1.2 million
- 2 individuals with costs in the $700,000s
- 1 individual with costs in the $600,000s
- 2 individuals with costs in the $500,000s
- 8 individuals with costs in the $400,000s
- **20 individuals with costs in the $300,000s**
- 16 individuals with costs between $255,000 and $299,999

40% of individuals had costs in the $300,000s

Complex Social Issues

A Case Study -- Client #1

- Recovering from brain injury and co-morbid depression
- Type 2 Diabetes
- Living with chronically ill adult son and chronically ill grandson
- Housed but in substandard housing
- Behind on utility payments
- Challenged credit

Work in Progress

- Electronic data sharing program with interface for care team and client (SharePoint)
- Complete housing inventory assessment and develop new housing options
- Develop protocols to expand to community health providers.

Data Sharing

- Issue: How do multiple partners across multiple systems share pertinent client data?

- Data sharing system requirements:
  - Quick implementation
  - Easy to use and maintain
  - Allows multiple users with various permission levels
  - Simple interface that can be accessed by various systems
  - Can support a client facing page
  - Budget friendly

- Our Solution: Sharepoint

What's Working
Becoming an Integrated System

- Collaborative partners.
- Addition of Community Health Outreach Worker to care team (new to Solano County).
- Clients engaged in their own success and part of their own care team.
- Good key hires with energy and enthusiasm a commitment to integrated, whole person care.

Our Opportunities

- Achieve Triple Aim by improving population health, improving client experience, and reducing costs.
- Focus on housing and increasing affordable housing stock.
- Develop a shared data platform that supports an integrated care approach.
- Breaking down traditional silos within H&SS and between community providers.
- Create shared goals and shared incentives for county and community providers.