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.
  o Integrated medical/mental health/substance abuse/dental services
  o Housing services
  o Social determinants of health (Community Health Outreach Workers)
An Integrated Multi-Agency Approach

**Lead Agency**
Solano County & DH&SS

- Contract with the State
- Data Analysis
- Care Coordination
- Clinical Components
  - Medical
  - Behavioral Health

Contracts With

**Solano Coalition for Better Health**

- Facilitation of public and private entities
- Program Management
- Development and partnership with Housing Authorities
- Community Health Outreach Workers

**Partners**

- Partnership HealthPlan
- Hospitals
  - NorthBay
  - Kaiser
  - Sutter
- Community Clinics
- Law Enforcement
About the Solano Coalition

• 28-year old agency that started the Partnership Health Plan
• Cooperative organization that includes most WPC partners:
  o County H&SS
  o Local Hospitals and their integrated medical clinics
  o Partnership Health Plan
  o Community clinics (FQHC’s)
  o Community Clinic Consortium
  o 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:
  o Quick implementation
  o Easy to use and maintain
  o Allows multiple users with various permission levels
  o Simple interface that can be accessed by various systems
  o Can support a client facing page
  o 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.