Whole Person Care – Los Angeles;

striving toward an integrated health delivery model

Leepi Shimkhada, MPP
Flora Gil Krisiloff, MBA
Gary Tsai, MD
Belinda Waltman, MD

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Health Services
LOS ANGELES COUNTY

Outline

- Introductions
  - **Leepi Shimkhada, MPP | Director of Housing and Services, Housing for Health**
  - **Flora Gil Krisiloff, RN, MN, MBA | Chief of Countywide Justice Program, Dept of Mental Health**
  - **Gary Tsai, MD | SAPC Medical Director & Science Officer**
- Whole Person Care Overview
- WPC Housing for Health Programs
- WPC Department of Mental Health Programs
- WPC Substance Use Disorder – Engagement Navigation and Support program
- Q&As

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WPC Overview

- Mission: Build an integrated delivery system & countywide infrastructure that delivers seamless, coordinated services and improved care to the highest-risk LA County Medi-Cal residents

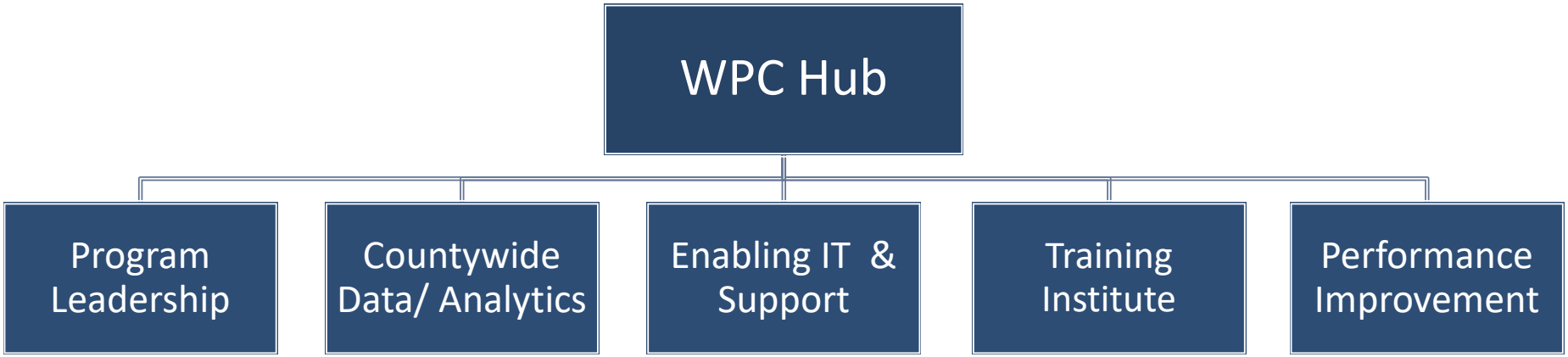
- Part of the 1115 Medicaid waiver

- Five year pilot 2016-2020

WPC Key Features

- Integrated health delivery system
  - Novel IT tools and Care Management Platform
- Community Health Worker-driven social service teams
  - Jobs for individuals with shared lived experience
- Regional complex care management model with “Any Door” entry
- Care coordination focused on high-risk times
  - Linkage to & Integration with the existing longitudinal providers

Central Program Structure

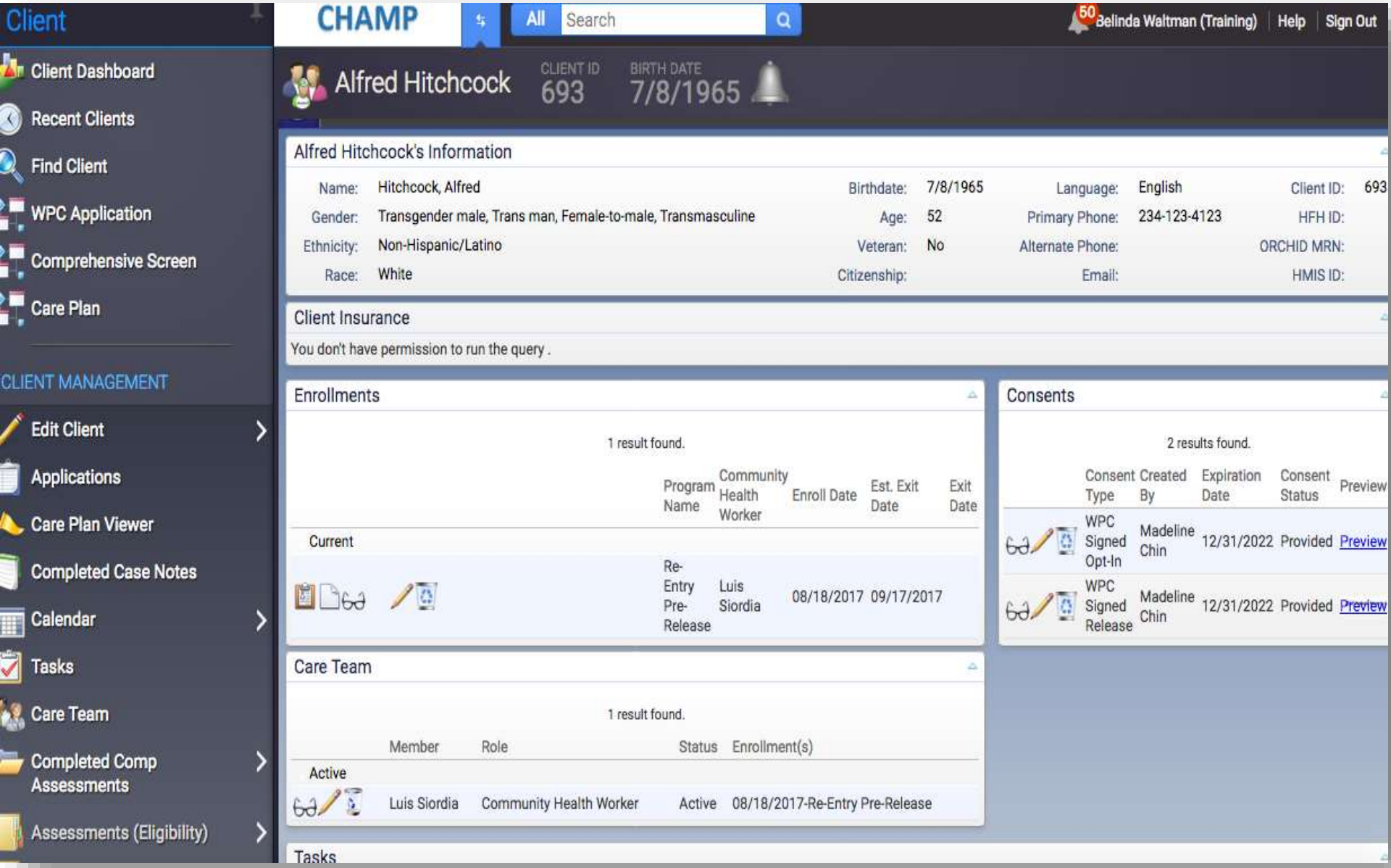


Program Leadership	Countywide Data/ Analytics	Enabling IT & Support	Training Institute	Performance Improvement
<u>WPC Leadership</u> • Management Advisory Board/ Workgroups	• Data Sharing/ Integration • Health Plans, Integration Hub	• **CHAMP** – **C**omprehensive **H**ealth **A**ccompaniment & **M**anagement **P**latform	• Training Collaborative & Capacity Building Approach	• Evaluation & Learning Team – Relentless pursuit of quality
• County Inputs	• Deep Analytics	• **One Degree** Community Resource Platform	• Partnerships & Community Action Teams	• Improvement Advisors to support PI activities

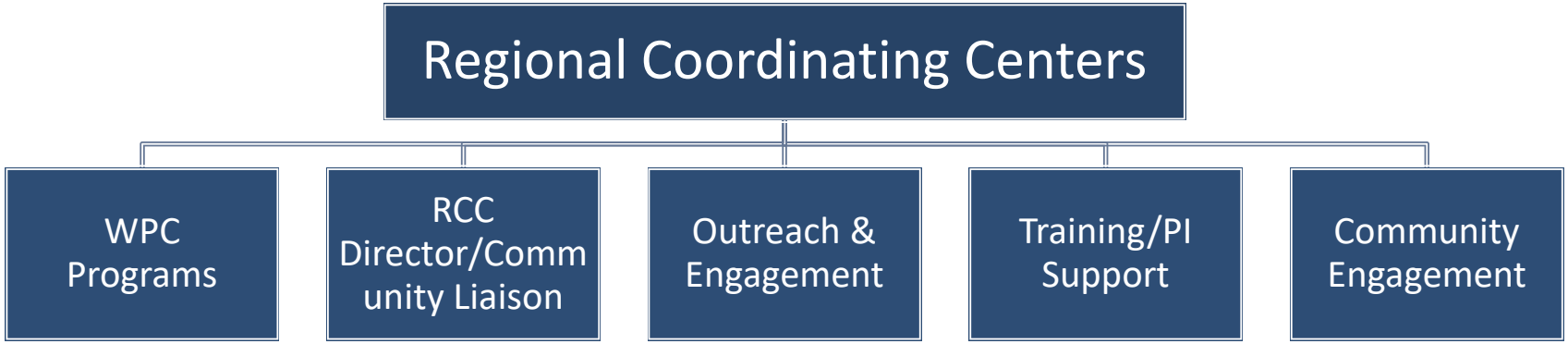
WPC Care Management Platform (CHAMP)

- User-friendly Care Management Tool
- Mobile platform on tablets or phones
- Built-in decision support
- Accessible for all end-users
- Enables:
  - Client screening, eligibility, and enrollment
  - Comprehensive Needs Assessment
  - Care Planning
  - Streamlined note writing
  - Metrics collection
- Goal for county-wide data integration

WPC Care Management Platform (CHAMP)

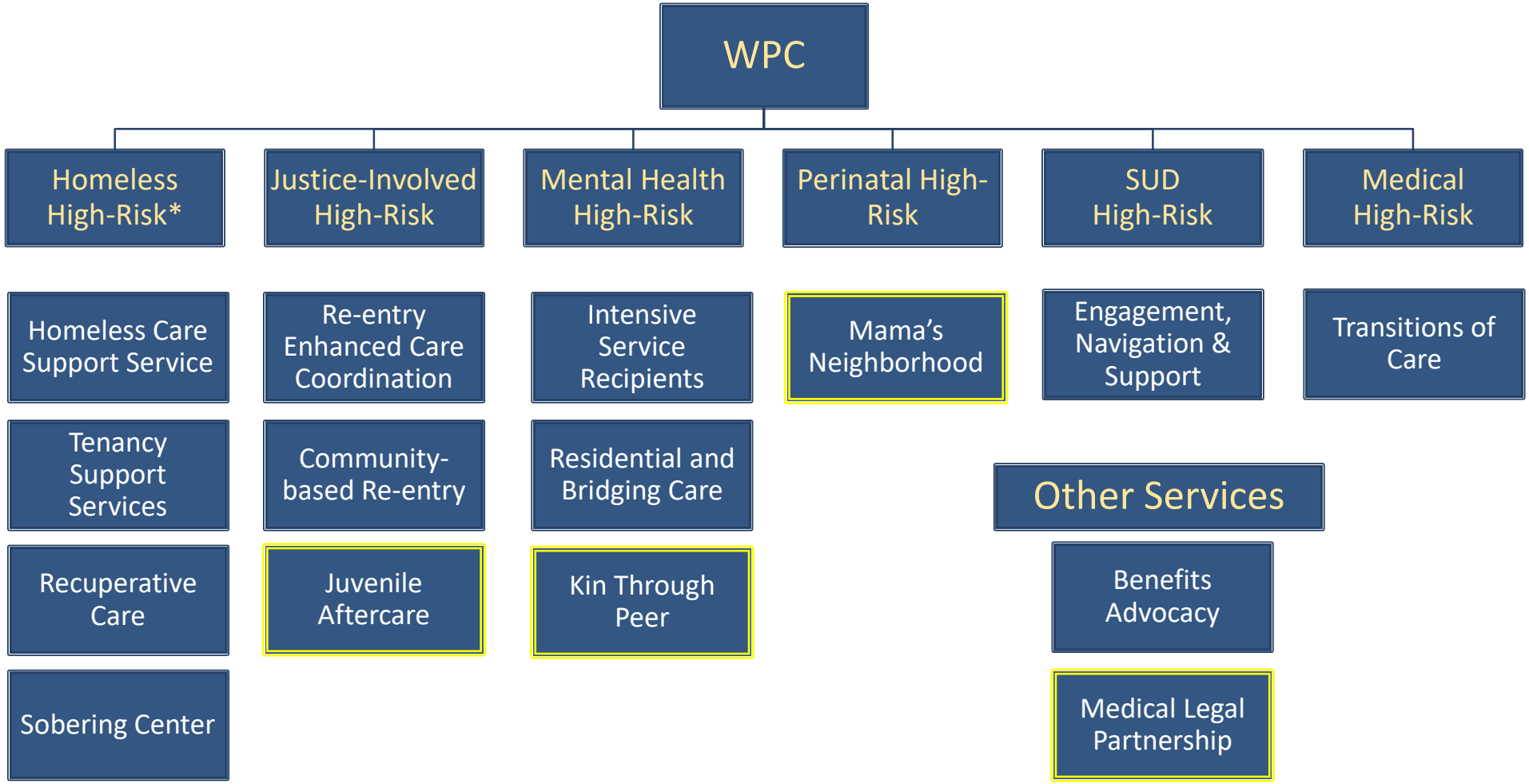


Regional Delivery Approach



- Regional Home & Staging Center for each program
  - Outreach & engagement – real-time engagement at point of care
- Training & Performance Improvement activities
  - Case Conferences & Learning Collaboratives
- Community engagement to fill gaps, create capacity, & strengthen regional delivery system
  - **Community Action Teams**

Populations & Programs

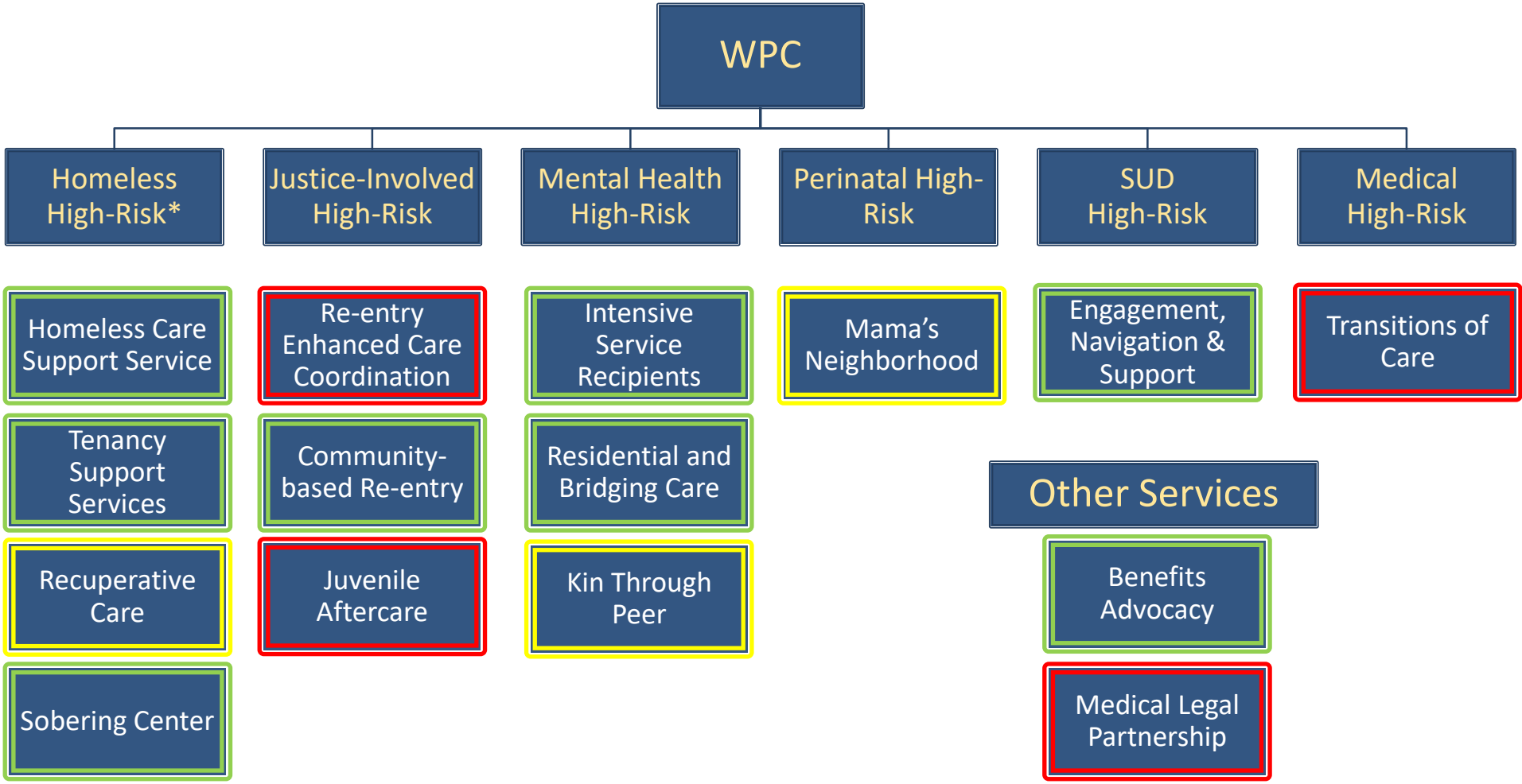


*Does not cover housing subsidy

WPC Eligibility

1. LA County Resident
2. Medi-Cal Beneficiary (certain types)
3. Meet WPC program inclusion criteria

Populations & Programs



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Referral Pathways

Inviting Referrals to Whole Person Care - Los Angeles Programs!

If you are working with an Los Angeles County resident who is Medi-Cal eligible, consider our programs…

…Community Re-Entry Program:

- Has been released from jail or prison within the last three months
- Has ongoing needs due to physical and mental health problems, substance use, or social needs

…Intensive Services Recipients Program:

- Is an individual with serious mental illness who has had 4 or more admissions within the past year
- Has been recently discharged from a psychiatric hospital
- Living in SPA 2, 3, 4, or 8

…Substance Use Disorder-Engagement Navigation & Support Program:

- Has active, persistent drug or alcohol use and wishes to stop using substances at the time of referral

→ CALL the WPC-LA Referral Line: 844-804-5200

…Homeless Care Support Services & Tenancy Support Services Programs

- Is homeless and would like help with housing
- Has other health problems or frequent visits to the emergency departments or hospitals

→ REFER to your local Coordinated Entry System (CES) provider

…Sobering Center

- Is intoxicated and does not require immediate medical attention
- Is willing to visit the Sobering Center

* Note: Currently with one location serving ONLY the Skid Row area of downtown Los Angeles

→ CALL Exodus: 213-395-7700

OR

REFER to E6 Street Outreach Team, EMS 1st Department, or Law Enforcement serving Skid Row

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...Residential & Bridging Care Program

- Is currently residing in an Institution of Mental Disease or Enriched Residential Setting, but you believe could be placed in the community with support

CALL the DMH Countywide Resource Management Referral Line & speak to the "Officer of the Day":

213-738-4775

...Benefits Advocacy Program

- Is over 65 or has a disability and would like to apply for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)

REFER to your local provider:

SPA 1	661-948-8559
SPA 2	818-342-5897 x2157
SPA 3	626-593-2364
SPA 4	213-334-1633
SPA 5	310-399-6878
SPA 6	323-432-4399
SPA 7	562-373-5264
SPA 8	562-599-1321

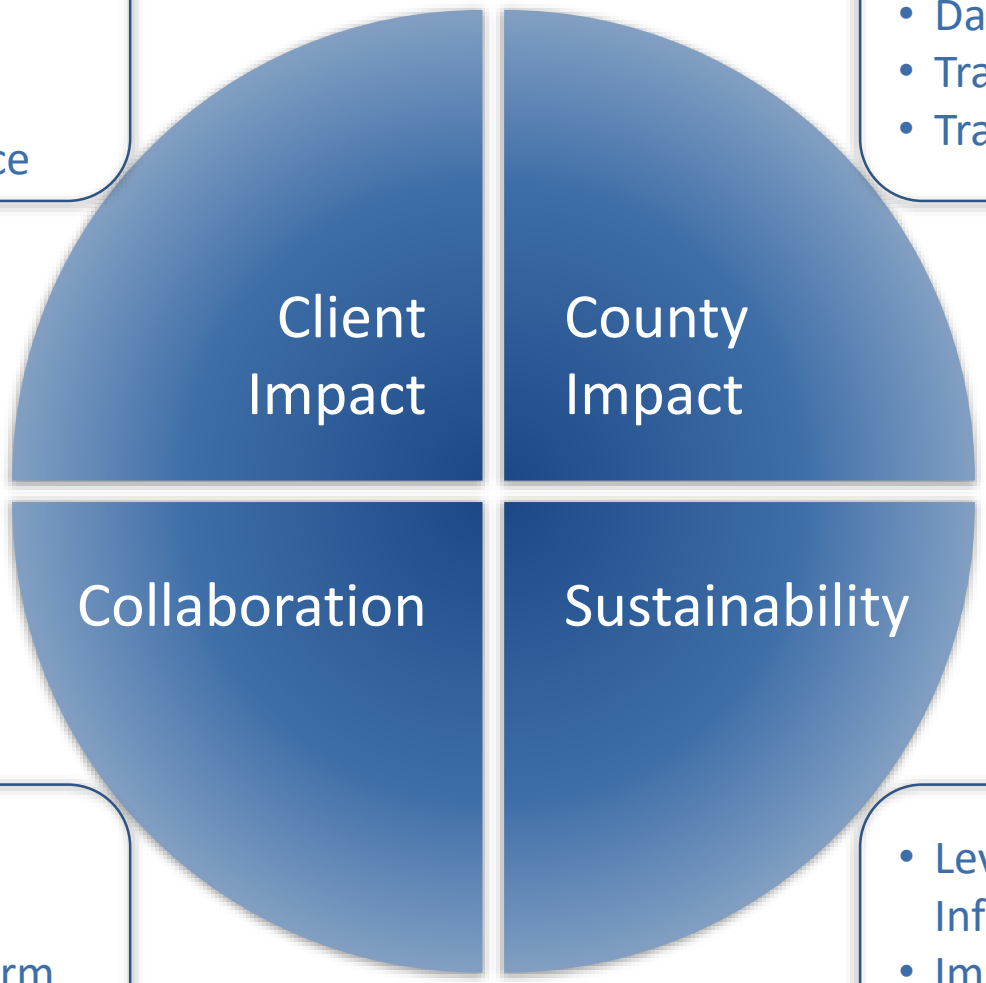
Linkage to Primary Care

- WPC goals/metrics
  - PCP Notification of patient enrollment in WPC
  - PCP assignment and appointment made within 30 days of WPC enrollment
  - CHWs trained in PCP accompaniment
- County-wide Primary Care Advisory workgroup to help address these issues

Overarching Impacts

- ~50,000 served annually
- ~9000 housed
- Support at times of highest risk
- Improved experience

- ~600 new jobs
- Largest Reentry Effort
- Data Integration
- Training & PI Institute
- Transportation



- Shared governance
- Cross-county collaboration platform
- Increased community partner engagement

- Leverage WPC Infrastructure
- Improve value (CQI)
- Broad ROI
- Policy Advocacy

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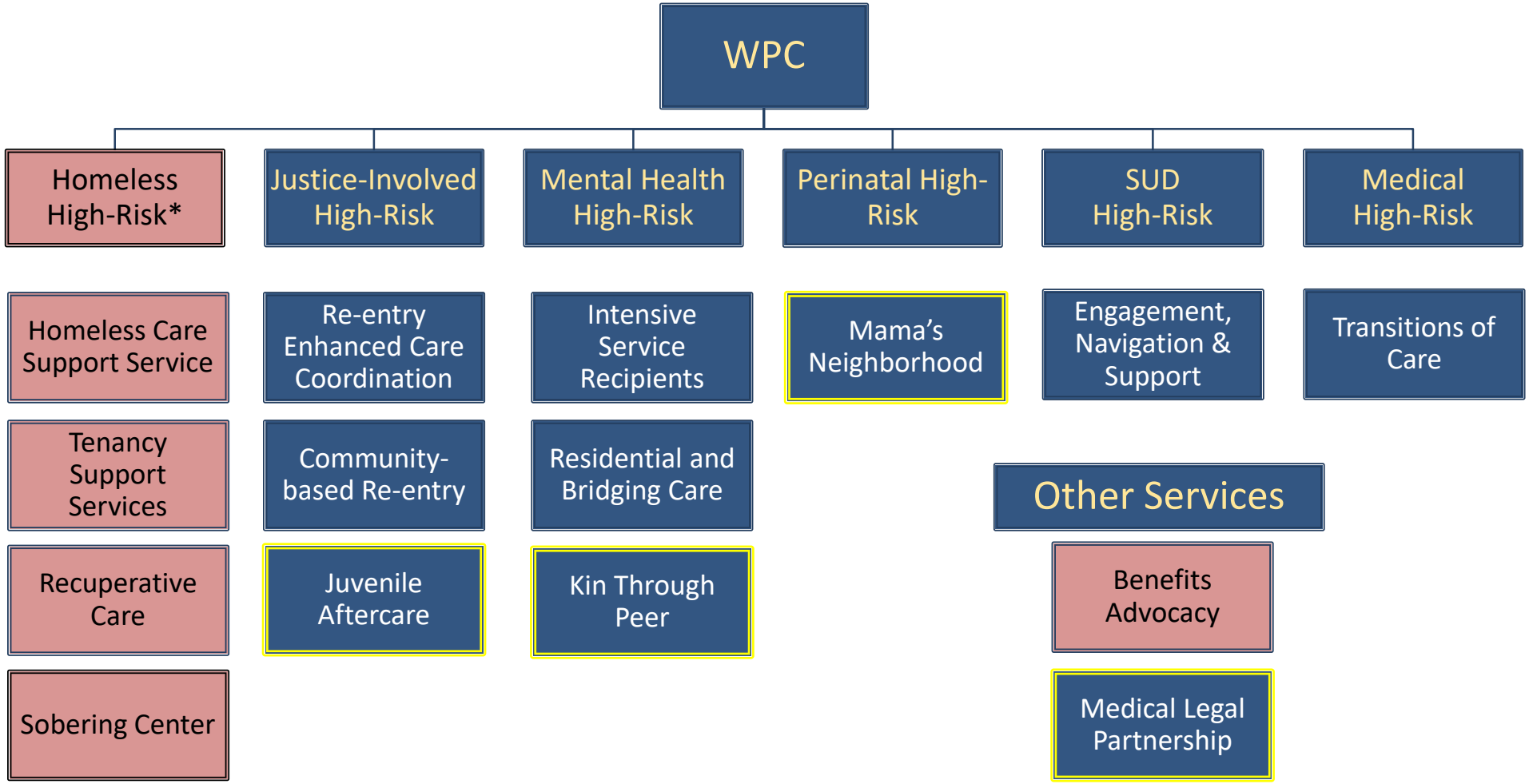

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Housing for Health Programs

- HFH Programs
  - Interim Housing
  - Permanent Supportive Housing
  - Rapid Rehousing
  - In Home Care Giving
  - Higher Level of Care
  - Benefits Advocacy
  - Countywide Street Based Outreach
  - Sobering Centers

INTERIM HOUSING

Recuperative Care (~300 Beds)

- Provides short-term care for homeless clients who are recovering from an acute illness or injury or have a condition that would be exacerbated by living on the street or in shelter
- Program offers temporary housing, medical and mental health monitoring, meals, case management, and transportation

Stabilization Housing (~500 Beds)

- Provides short-term housing and support for homeless clients who are moving into permanent housing soon
- Program offers temporary housing, meals, case management, and transportation

PERMANENT SUPPORTIVE HOUSING

- Permanent housing for persons experiencing homelessness. Rental subsidies and services are not time limited. Models can be scattered site or project based with on-site/mobile supportive services for homeless clients who are high acuity.
- Housing for Health believes in a “whatever it takes” approach which is supported by evidence based practices such as, housing first and harm reduction.
- Intensive Case Management Services (ICMS) funded through contracts with DHS.
- Specialty programs available for Housing for Health participants:
  - In Home Care Giving
  - Higher Level of Care
- Outcomes to date: over 3500 housed with a 96% retention rate after being housed for 1 year.

RAPID REHOUSING

- Time limited rental assistance and targeted supportive services for clients with low to moderate housing barriers
  - DHS' Rapid Rehousing program is called the Housing and Jobs Collaborative.
  - The program offers time limited rental assistance and linkage to employment services with the goal of increasing one's income to support rental costs and to reintegrate back into their community of origin.

COUNTYWIDE BENEFITS ADVOCACY

- County Homeless Initiative (Increase Income Category):
  - C4, C5, C6 – renamed Countywide Benefits Entitlement Services Team (C.B.E.S.T.)
- Holistic approach to benefits advocacy
  - Benefits advocacy and linkage to housing and services
  - “Whatever it takes” approach
  - SOAR national best practice
- Co-located in 14 General Relief District Offices, community based locations and in custody facilities

COUNTYWIDE STREET BASED OUTREACH

- Homeless Initiative E6 (Create a Coordinated System category)
- A coordinated outreach system to reduce duplication of services and increase efficiencies through the investment of resources for:
  - Coordinated Entry System (CES) Outreach Coordinators
  - Centralized Call/Referral Center
  - Generalized Outreach Workers
    - CES Outreach
    - Emergency Response Teams
  - Multidisciplinary Outreach Teams
    - Health, Mental Health and Substance Use Disorder specialists

SOBERING CENTERS

- 24/7 facilities that provide safe, short term monitoring and management of persons under the influence of alcohol and drugs.
- Sobering centers will provide an alternative destination for law enforcement and fire departments to send people whose primary presenting issue at the time of contact is severe intoxication rather than an acute medical crisis. Clients are also referred into sobering centers by street outreach teams and hospital emergency rooms.
- The Dr. David L. Murphy Sobering Center in downtown Los Angeles opened in January 2107. A sobering center serving the Westside is expected to open around the end of the year.

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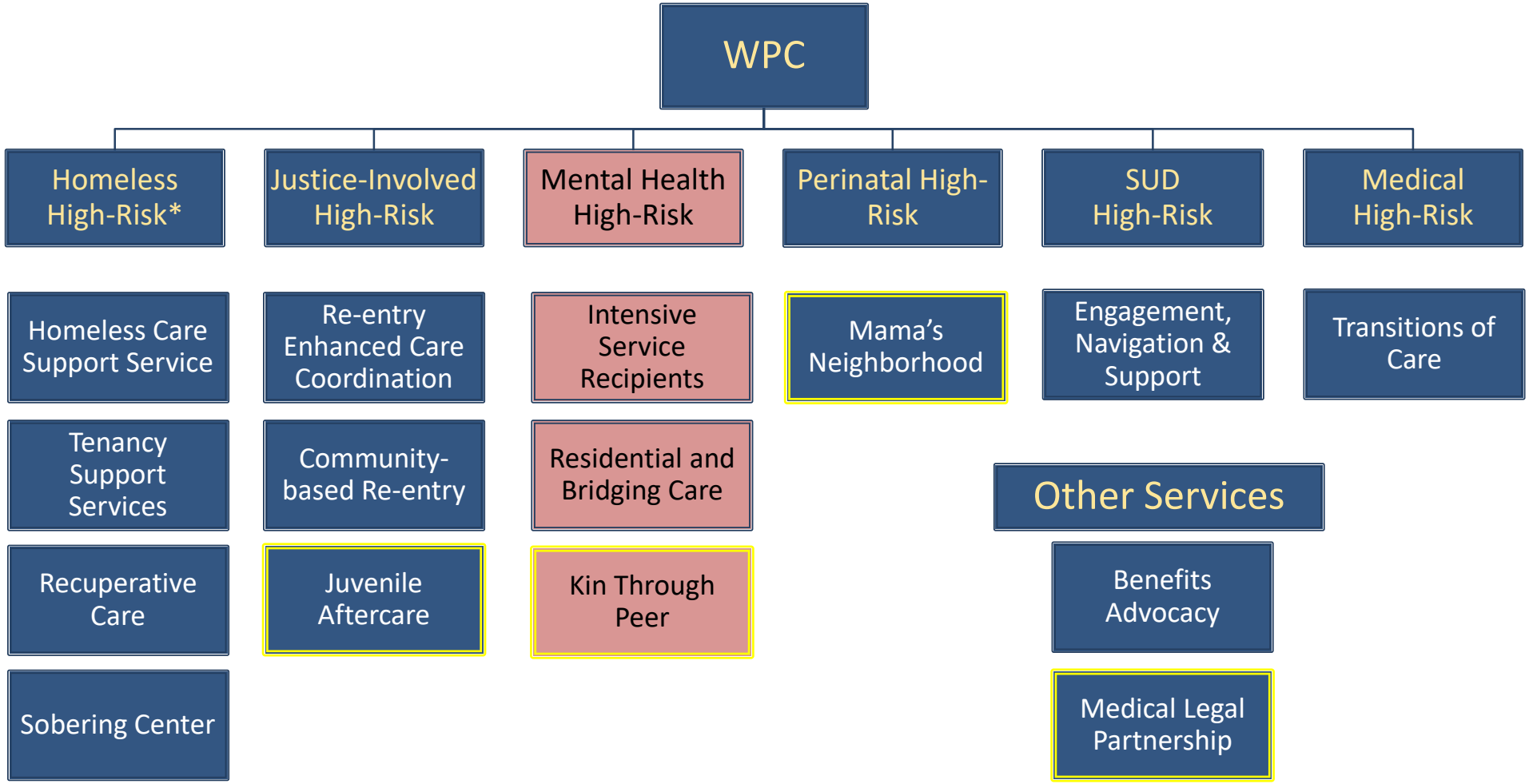

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WPC DMH programs:

- Intensive Service Recipients (ISR)
- Residential and Bridging Care (RBC)
- Kin Through Peer (KTP)

Intensive Service Recipients (ISR)

- Program serves adults with serious mental illness
- With a minimum of four psychiatric hospital admissions in the previous year at Department of Mental Health fee-for-service hospitals and/or county psychiatric hospitals
- Three months of comprehensive care coordination services
- Primary goal is to establish effective linkage to mental health and other care providers to reduce repeat psychiatric hospitalizations

ISR Program Services

- Program screening , assessment and enrollment
- In-hospital and in-home visits with a care coordination team
- Collaboration and participation in hospital discharge planning
- Assistance with referral and linkage to appropriate services
- Planning a daily program following release from hospital
- Medication adherence supports
- Assistance in arranging supportive services, such as transportation, housing and food

Residential and Bridging Care (RBC)

- DMH Countywide Resource Management (CRM) RBC program expands CRM's existing Residential and Bridging Services
- The RBC Care Transition Team serves individuals who are ready for discharge from County Hospital Psychiatric Emergency Services (PES) and psychiatric inpatient units, Institutions for Mental Disease (IMD), and Enriched Residential Services (ERS) programs
- Three months program identifies individuals who are ready to return to non-institutional settings, strengthens existing discharge planning functions and supports eligible clients in their transition back to the community
- The team also addresses individuals' delays in discharge due to inability to arrange timely placement, services, and supports necessary for successful transitions to lower levels of care

RBC Program Services

- RBC Care Transition Team collaborates with the Department of Health Services, IMDs, and ERS programs to develop aftercare plans for clients with intensive and complicated service needs

- Team assists the Psychiatric Emergency Services and Psychiatric Inpatient Units at the County hospitals, IMDs, ERS programs and three specialized ERS and Full Service Partnership (FSP) programs (Assisted Outpatient Treatment, Misdemeanor Incompetent to Stand Trial, and Alternative to Custody) with discharge planning and linkage to community-based resources

- RBC program coordinates discharge planning with conservators, family, and/or other social supports as appropriate; ensures enrollment in and warm had-offs to mental health services, including Integrated Mobile Health Teams , FSP Programs, Field Capable clinical Services, Wellness Centers, and outpatient services

Kin Through Peer (KTP)

- The Kin Through Peer (KTP) program under development will serve clients who are eligible for the Intensive Service Recipient or Residential and Bridging Care programs, and lack healthy family relations or healthy social support systems
- KTP clients suffer from a serious mental illness and languish in the context of extended stay in residential facilities or regular transitioning in and out of psychiatric ERs/Hospitals
- The 12 months KTP Program Team will reach out to a subset of ISR and RBC program clients to identify 400 of the highest-need recipients of WPC-LA services that would benefit from longer-term, peer navigator services to act as support kin
- KTP clients will be identified by ISR and RBC team members and referred to the KTP program

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WPC Substance Use Disorder Engagement, Navigation, and Support (SUD-ENS)

- In partnership with Substance Abuse Prevention and Control (SAPC) and the Drug Medi-Cal Waiver
- Two month navigation program for high-risk individuals with substance use disorders
- Objectives: to help high-risk individuals get connected to and remain in treatment, and reduce unnecessary utilization

WPC Substance Use Disorder Engagement, Navigation, and Support (SUD-ENS)

- Each client will be paired with a Community Health Worker (CHW) who will help them engage in treatment, accompany them to provider visits, address other social needs, support relapses, and assist in transitioning between levels of care
- Many CHWs have a shared lived experience with the client population

SUD-ENS Inclusion Criteria

- Active Substance Use Disorder
- **AND** Willing to receive treatment
- **AND** any of the following in the past 12 months:
  - 3+ SUD-related ED visits
  - 2+ SUD-related inpatient hospital admissions
  - 3+ sobering center visits
  - 2+ residential treatment programs
  - 2+ SUD-related incarcerations
  - Drug court referral
  - Homelessness with concurrent SUD
  - History of overdose (in the past 2 years)
  - Pregnant with concurrent SUD
  - Active IV drug use

Relationship with other SUD services

WPC CHW provides support until residential treatment bed available

Residential treatment

WPC CHW helps support transition to intensive outpatient therapy

Intensive Outpatient Tx

WPC CHW helps support transition to intensive outpatient therapy

Regular Outpatient Tx

WPC (SUD-ENS) Current Referral Sources

- SAPC's 24/7 Substance Abuse Service Helpline (SASH)
- WPC Referral Call Line (from the community)
- Hospitals
- Community Clinics
- Skid Row Sobering Center
- SUD Treatment Facilities – at time of discharge, if discharge plan is already in place

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Questions?

WPC Information:

wpc-la@dhs.lacounty.gov

www.dhs.lacounty.gov/wps/portal/dhs/wpc