HICCE Innovation Project – Final Report
Placer County Behavioral Health

Project Name: MHSA Homeless Integrated Care Coordination and Evaluation (HICCE) Innovation (INN) Project

Project Dates: January 26, 2017 – January 31, 2022

1. **Provide a brief summary of the priority issue related to mental illness or to an aspect of the mental health service system for which the County chose to design and test the INN Project.**

The vision of the MHSA Homeless Integrated Care Coordination and Evaluation (HICCE) Innovation (INN) Project was to:

- Build upon our existing infrastructure and organizational programs to create a comprehensive network of care in Placer County to improve services to the homeless and other high-risk individuals;
- Learn how to expand and strengthen collaboration and coordination of services across agencies and organizations to promote access, address unmet needs, and improve outcomes; and
- Learn how to support data sharing across diverse entities to create a safety net that meets the complex needs of persons who are homeless and/or have chronic health conditions,
- Utilize evaluation activities to share outcomes, identify barriers to success, and identify when the system is meeting the needs of complex individuals.

The Innovation Project utilized the HICCE vision to support the activities of the Whole Person Care (WPC) project by creating the capacity to build collaboration, develop Memorandums of Understanding (MOUs), and create agreements needed to collect and share information across organizations and utilize evaluation activities to share outcomes. This created a continuous evaluation and feedback process to modify and improve services, meet individuals' needs, and achieve positive outcomes, such as stable housing; reduce Emergency Department (ED) utilization; reduce physical and psychiatric hospitalizations; reduce recidivism; and help manage health and behavioral health needs.

This Innovation Project, herein after referred to as "WPC/HICCE" due to its integration within the WPC project, developed strategies to utilize multiple resources to create a cohesive safety net to quickly identify high-need individuals, engage and link them to needed services, and evaluate the success of the collaboration over time. This project implemented technology (Pre-

Manage) to help immediately identify people when admitted into the Emergency Department (ED) to ensure the Team responds within a short period of time to offer services to meet the individual's needs. This project also utilized technology to develop the capacity to identify persons who are homeless, individuals in the shelters, and/or persons released from higher levels of care, including justice-related settings.

2. **Describe any changes that the County made to the INN Project during the course of its implementation and evaluation, and the reasons for and impact of the changes, including any changes in the timeline.**

The five-year implementation of WPC/HICCE was consistent with the initial plans. As new technology became available, the Pre-Manage electronic notification system was implemented to enhance communication across partner agencies. For example, the Pre-Mange programs was purchased and installed in the ED of the local hospital. When a WPC member was admitted to the ED, the WPC team was immediately notified that a WPC member was admitted. This created the opportunity for a WPC staff person follow-up with the WPC member within 7 days of the ED visit. Often, the WPC staff member could respond to the ED to help de-escalate the crisis and prevent an inpatient hospitalization, immediately. The WPC staff person was familiar with the member and knew their history and current treatment. This often helped to resolve the emergency and meet the member's needs in the community, which reduced the number of hospitalizations over time. This helped to meet the goals of the WPC and meet the needs of the individual.

There were 504 persons served in WPC/HICCE. These individuals were enrolled in one or more "bundles" to meet their needs. Services varied in each bundle to meet the needs of each WPC member. Of the 504 members, 461 were briefly enrolled in the Engagement Bundle. This allowed WPC to provide services immediately to meet their basic needs. Since many of the individuals served by the WPC program were homeless, basic care items, such as clothing; shoes; tents; sleeping bags; and food were offered to keep the engagement and build trust between staff and the individual. During the engagement process, individuals were assessed for their needs, mental health symptoms, and substance use. Of the 504 WPC members, 253 were enrolled in the Comprehensive Complex Care Coordination (CCCC). This bundle of services provided mental health; SUD; nursing; case management; and other services to resolve their immediate and long-term needs.

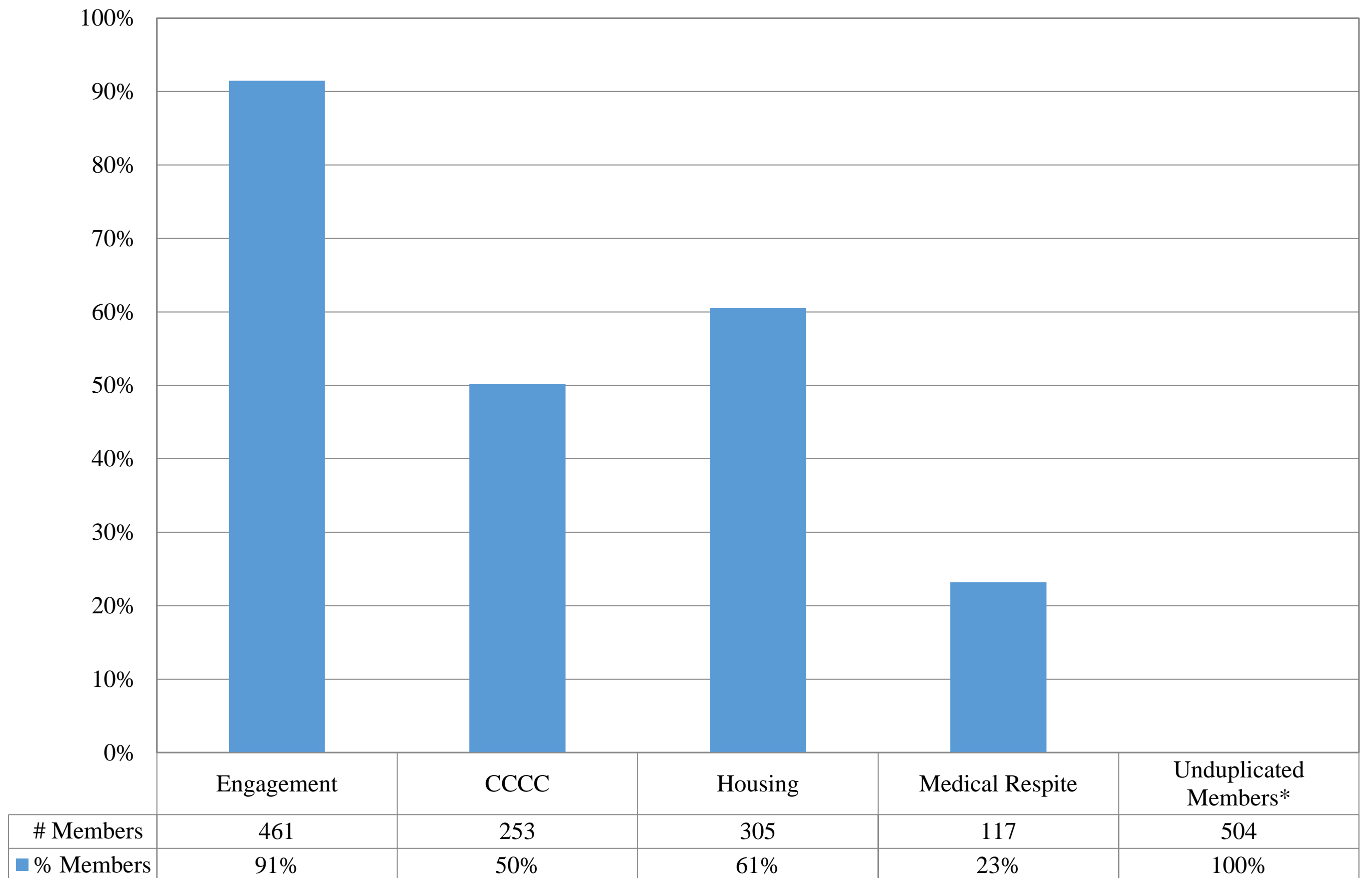
The Whole Person Care Pilot Program concluded at the end of 2021. In 2022, program services were transitioned into the new CalAIM Enhanced Care Management/Community Supports initiative. HHS is committed to continuing to

promote and strengthen collaboration across all agencies to continuously improve access, quality, coordination, and cost-effectiveness of services.

3. Provide program information collected during the reporting period, as specified in Section 3580.010, subdivision (a)(4).

Pilot Year 1 of the WPC Pilot was dedicated to writing the WPC Pilot application and planning innovation and implementation activities. The WPC Team began enrolling members in April 2017 and served 504 WPC members throughout the life of the project. The 504 individuals that received services in WPC were enrolled in one or more "Bundles" to meet their needs. Services varied in each Bundle to meet the needs of each WPC member. Figure A shows the number of members enrolled in the WPC program. There were 504 unduplicated members. Of these, 461 were enrolled in the Engagement Bundle (91%); 253 in the CCCC Bundle (50%); 305 in the Housing Bundle (61%); and 117 in the Medical Respite Bundle (23%).

Figure A
Enrollment in <u>Bundles</u> for All Members



	Engagement	CCCC	Housing	Medical Respite	Unduplicated Members*
# Members	461	253	305	117	504
% Members	91%	50%	61%	23%	100%

The WPC Team has excelled at meeting the key metrics required by DHCS. For example, the WPC Team completed Assessments and Tailored Plans of Care within 30 days of enrollment.

Across the program, there were 253 unduplicated individuals who were enrolled in CCCC. The sum of the enrollments across the years is slightly higher because there were a few individuals who were served, discharged, and then re-enrolled in CCCC. Out of the 253 unique CCCC members, 248 (98%) had completed Assessments and Tailored Plans of Care within 30 days of enrollment. This illustrates how services have been implemented and are successful at identifying and linking high-need individuals to the appropriate level of services.

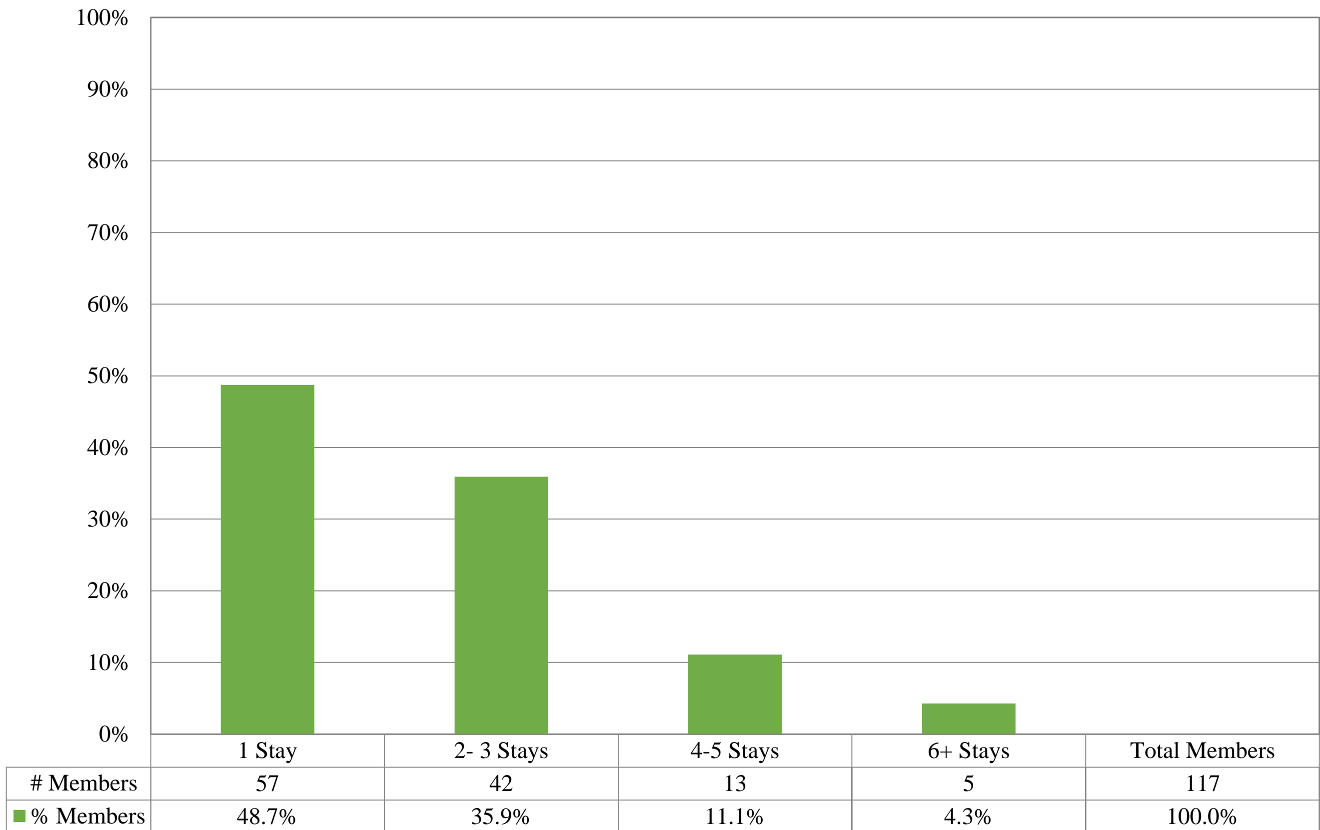
The majority of WPC members experienced homelessness when they entered the program. The WPC Team enrolled members in the Housing Bundle to provide housing services for these individuals. The Housing Bundle included several components: 1) intensive services to help members become "housing ready;" 2) services to identify and resolve barriers to the member meeting their goals; 3) ongoing coordination with landlords, or potential landlords; and 4) ongoing support to members after they were placed in a stable living situation. Of the 504 WPC members served, 305 were enrolled in the Housing Bundle (61%).

The WPC program also opened a Medical Respite program, which supported collaboration between WPC, Adult System of Care (ASOC), and the organizational provider. Placer County contracted with The Gathering Inn (TGI) to operate the Medical Respite program. TGI had previous experience operating a medical respite program and was successful at quickly implementing this program. The Medical Respite provided services to homeless individuals who were discharged from a hospital or had additional needs to help recover from their physical health conditions.

The TGI case management staff worked closely with WPC staff to help link members to their medical providers, advocate for members to secure benefits and other services, link members to home health care, and enroll members with In-Home Supportive Services. In addition, these members became a high priority for housing support services. The collaboration between agencies has been effective at helping to stabilize an individual's physical health conditions as well as achieving positive outcomes by identifying additional housing resources. There were 117 unduplicated members who received Medical Respite care for any length of time.

Of the 504 WPC members served, 117 utilized Medical Respite services (23%), with the majority experiencing health improvement at discharge. Figure B shows that there were 117 members admitted to Medical Respite and the number of stays at the Medical Respite program. There were 57 members that had one stay/admission (48.7%); 42 members had two-three stays/admissions (35.9%); 13 members had four-five stays/admissions (11.1%); and five (5) members had six or more stays/admissions (4.3%). The Medical Respite program has been extremely effective at helping to treat and resolve the complex health issues for individuals who are homeless and have behavioral health issues.

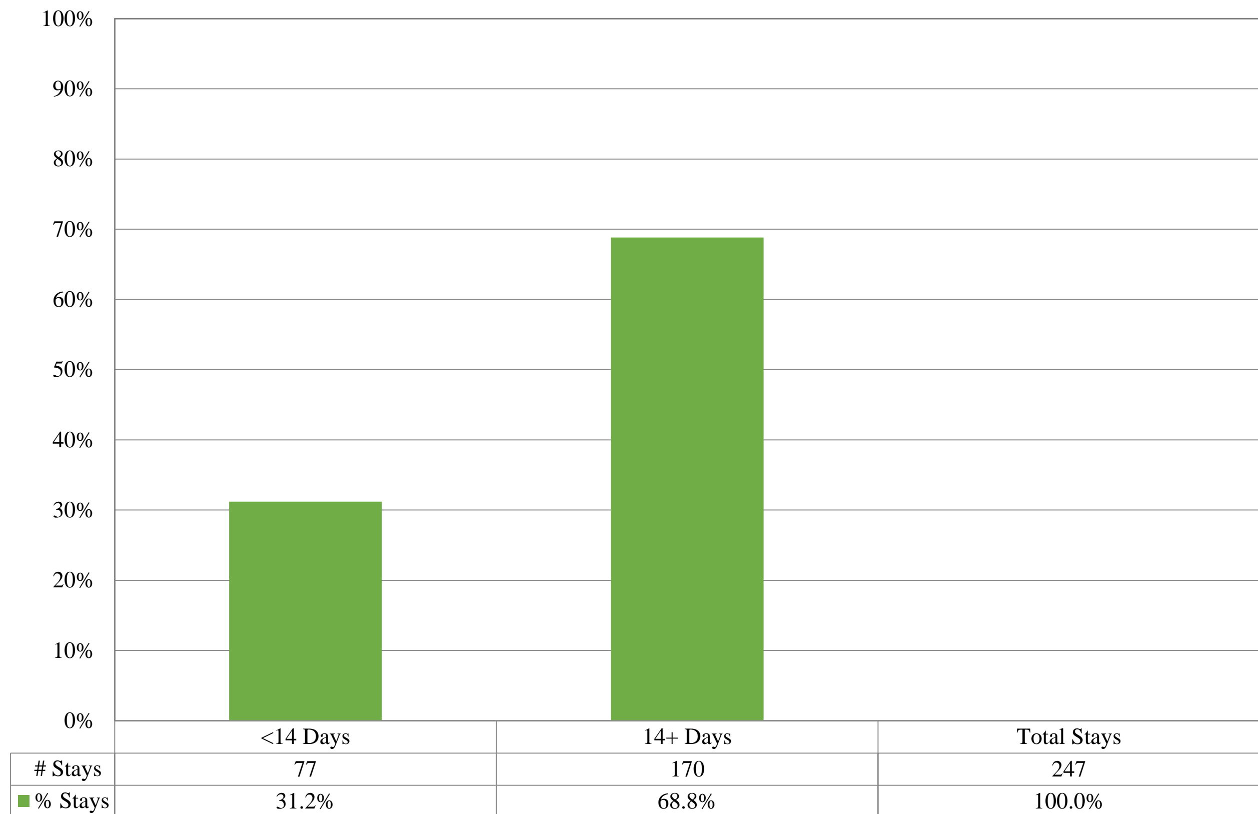
Figure B
Medical Respite Bundle Members
Number and Percent of Medical Respite Members,
by Number of Medical Respite Stays



	1 Stay	2- 3 Stays	4-5 Stays	6+ Stays	Total Members
# Members	57	42	13	5	117
% Members	48.7%	35.9%	11.1%	4.3%	100.0%

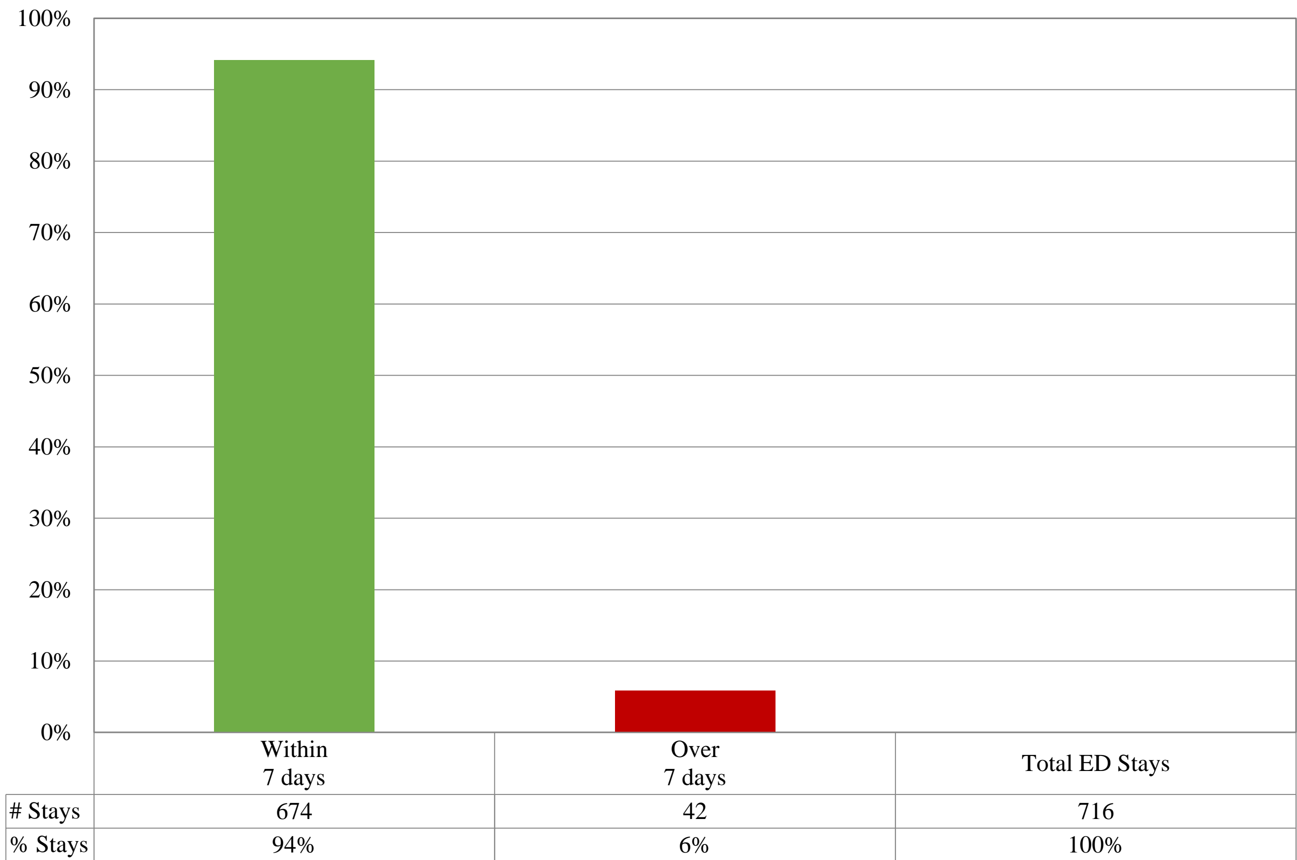
Figure C shows data for the Medical Respite program by the number stays/admissions. There were 117 unique members admitted to Medical Respite. Of the 117 members, there were 247 stays/admissions. Of those stays/ admissions, the length of stay was less than 14 days for 77 of them (31.2%). There were also 170 stays/admissions that lasted 14 days or longer (68.8%).

Figure C
Medical Respite Bundle Members
Number and Percent of Medical Respite Stays, by Length of Stay



The coordination and collaboration across systems, using PreManage, as well as ongoing and immediate communication with the Team and hospital/ED staff, has been extremely effective and results in the ability to follow-up on the majority of ED visits within seven (7) days. Figure D shows that across the 716 total ED visits by CCCC members, the WPC Team successfully followed up within seven (7) days for 674 (94%) of the ED visits. This shows the importance of using technology and strong collaboration across organizations, to improve outcomes for complex individuals.

Figure D
Members With Emergency Department Stay(s)
Number and Percent of Emergency Department Stays,
with Follow-up within 7 Days



	Within 7 days	Over 7 days	Total ED Stays
# Stays	674	42	716
% Stays	94%	6%	100%

4. Final evaluation results

a. Description of the evaluation methodology

The evaluation methodology used data reported by the team to Avatar, Placer County's electronic health record (EHR). In addition, a collaboration survey was collected every six months from all of the partner agencies, to document the level of coordination and collaboration across all of the agencies. This helped to document partnerships and organizations that work together to meet the needs of the members. Key outcome data was collected to document progress over time on homelessness; housing; responsiveness to follow-up after an Emergency Department visit; etc. Data is also reported and analyzed for individuals by type of service and key outcomes.

b. Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices

Implementation of the Pre-Manage software in the ED created an immediate, real-time notification to the WPC team, so the team would know when a WPC member was admitted to the ED. This provided the opportunity to quickly respond to the member and ensure that they had follow-up services within seven (7) days. For the 716 total ED visits by CCCC members, the WPC Team successfully followed up within seven (7) days for 674 (94%) of them. This model as found to be so effective that it has now been implemented across the Adult System of Care (ASOC).

Utilization of Pre-Manage also prompted the ASOC staff to learn more about the individual's health issues and become an active partner to determine if the individual is receiving the appropriate level of care. As a result of this information, individuals are being referred to the FSP program which helps them to support all of their health and behavioral health needs.

The housing program was also an important focus for WPC members. Since the implementation of the grant, 187 members were housed.

The Medical Respite program served 117 WPC members, for a total of 247 stays. Of those 247 stays, 170 (68.8%) were for 14 or more days.

c. **Any variation in outcomes based on demographics of participants, if applicable**

No variation in outcomes based upon the demographics of members was found during the analysis.

d. **Assessment of which activities or elements of the Innovative Project contributed to successful outcomes**

Three important components of the WPC project were the housing program; Medical Respite; and the Pre-Manage software to help identify members who were in the ED and hospital.

The housing program was very effective with the WPC members. Over the life of the grant, there were 187 persons who were housed! While the Housing Coordinator has worked extensively with the members, the members have also been actively trying to find housing. This has helped to create housing for a large number of members.

e. **Explanation of how the evaluation was culturally competent**

This program and evaluation were culturally competent. The team had a comprehensive understanding the culture of clients and how to engage and provide treatment to meet their needs. In addition, the team was very effective at working with the homeless population, reaching out to them in a culturally responsive manner to gain their trust and engage them in services. The team had the nursing staff available to meet the needs of the medically fragile and help them access the Medical Respite program, when needed. The team received a number of different trainings including cultural humility; implicit bias; motivational interviewing, and trainings directly related to persons who are homeless.

The following tables shows data for the number and percent of members by age; gender; and race/ethnicity. Figure E shows the 504 members by age. This program served persons ages 18 and older. There were 12 members that were ages 16-25 (2.4%); 302 members that were age 26-59 (59.9%); and 189 members that were 60 and older (37.5%). This is a large number of persons who were 60 and older and reflects how complex this population was for providing treatment.

Figure E
Number and Percent of All Members, by Age

	# Members	% Members
Children/Youth (0-15)	-	-
TAY (16-25)	12	2.4%
Adults (26-59)	302	59.9%
Older Adults (60+)	189	37.5%
Unknown	1	0.2%
Total:	**504**	**100.0%**

Figure F shows the 504 members by gender. The proportion of members was similar with 260 males (51.6%) and 241 females (47.8%). There were three (3) with unreported gender.

Figure F
Number and Percent of All Members, by Gender

	# Members	% Members
Male	260	51.6%
Female	241	47.8%
Unknown	3	0.6%
Total:	**504**	**100.0%**

Figure G shows the 504 members by race/ethnicity. There were 43 members who were Latino (8.5%); 17 who were American Indian/Alaska Native (3.4%); 14 who were Black (2.8%); 337 who were Caucasian (66.9%); and 18 who were other categories (3.6%). There were 75 that were Unknown (14.9%). The proportion of members served by each race/ethnicity category is consistent with the general population in Placer County.

Figure G
Number and Percent of All Members, by Race/Ethnicity

	# Members	% Members
Latino	43	8.5%
American Indian or Alaska Native	17	3.4%
Asian	-	-
Black/ African American	14	2.8%
Native Hawaiian or other Pacific Islander	-	-
White/ Caucasian	337	66.9%
Other	18	3.6%
Unknown	75	14.9%
Total:	**504**	**100.0%**

f. Explanation of how stakeholders contributed to the evaluation

To help evaluate and measure the HICCE and WPC collaboration and coordination across organizations, a Collaboration Survey was initially distributed to 44 agencies through email in July 2017. This online survey collected information on the levels of self-reported collaboration in July 2016 and July 2017. Follow-up surveys were distributed in January and July 2018, January and July 2019, January and July 2020, January and July 2021, and January 2022 to assess current levels of collaboration. Each agency was asked to rate collaboration with the other agencies using the following response options:

- No Interaction
    - No experience or interaction with organization
- Networking
    - Aware of organization
    - Loosely defined roles
    - Little communication
    - Independent decision- making
- Cooperation
    - Information sharing
    - Somewhat defined roles
    - Formal communication
    - Independent decision-making
- Coordination
    - Information & resource sharing
    - Defined roles
    - Frequent communication
    - Some shared decision making
- Collaboration
    - Information & resource sharing
    - Defined and/or shared roles
    - Frequent communications with mutual trust
    - Consensus is reached on shared decisions

A summary of the survey responses is provided. The following six (6) graphs display the 44 agencies' responses to the collaboration survey across the 11 time periods. The agencies are organized by the level of collaboration at the most recent reporting period (January 2022).

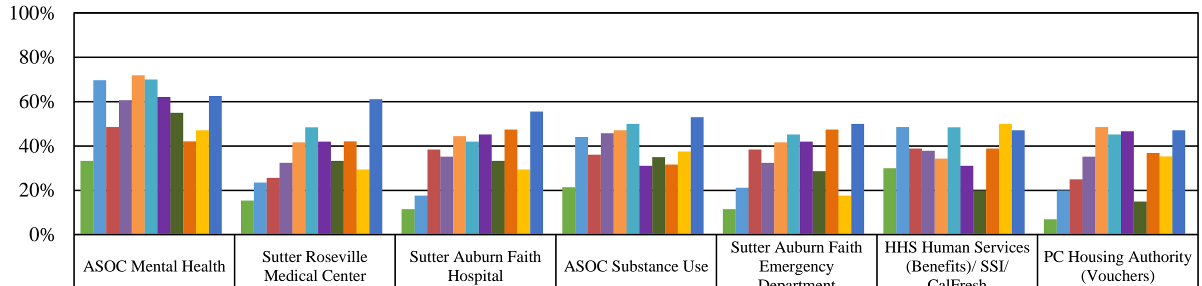
The percent of agencies reporting increased collaboration and coordination increased dramatically over the eleven time periods as these agencies became more involved with the WPC Team and HICCE program. For example, the percent of agencies reporting a collaborative relationship with the Adult System of Care Mental Health Program (ASOC Mental Health) was 33.3% in 2016 and

increased to 62.5% in 2022. Many agencies had an increased level of collaboration across the eleven time periods.

Figure H

Collaboration Survey: Percent of Coordination and Collaboration Between Agencies

July 2016; Twice per year July 2017 – January 2022

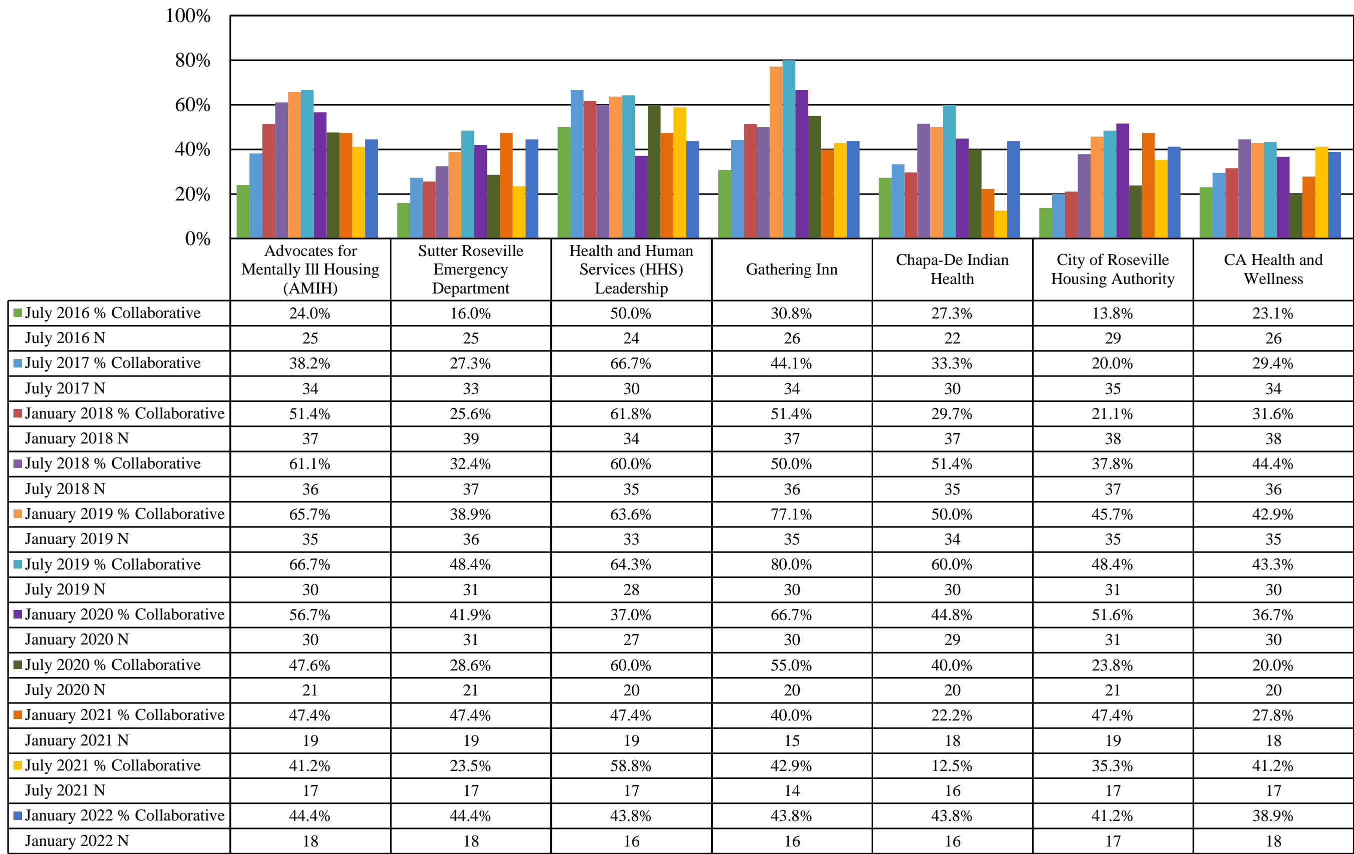


	ASOC Mental Health	Sutter Roseville Medical Center	Sutter Auburn Faith Hospital	ASOC Substance Use	Sutter Auburn Faith Emergency Department	HHS Human Services (Benefits)/ SSI/ CalFresh	PC Housing Authority (Vouchers)
July 2016 % Collaborative	33.3%	15.4%	11.5%	21.4%	11.5%	30.0%	6.9%
July 2016 N	27	26	26	28	26	30	29
July 2017 % Collaborative	69.7%	23.5%	17.6%	44.1%	21.2%	48.6%	20.0%
July 2017 N	33	34	34	34	33	35	35
January 2018 % Collaborative	48.6%	25.6%	38.5%	36.1%	38.5%	38.9%	25.0%
January 2018 N	35	39	39	36	39	36	36
July 2018 % Collaborative	60.6%	32.4%	35.1%	45.7%	32.4%	37.8%	35.1%
July 2018 N	33	37	37	35	37	37	37
January 2019 % Collaborative	71.9%	41.7%	44.4%	47.1%	41.7%	34.3%	48.6%
January 2019 N	32	36	36	34	36	35	35
July 2019 % Collaborative	70.0%	48.4%	41.9%	50.0%	45.2%	48.4%	45.2%
July 2019 N	30	31	31	30	31	31	31
January 2020 % Collaborative	62.1%	41.9%	45.2%	31.0%	41.9%	31.0%	46.7%
January 2020 N	29	31	31	29	31	29	30
July 2020 % Collaborative	55.0%	33.3%	33.3%	35.0%	28.6%	20.0%	15.0%
July 2020 N	20	21	21	20	21	20	20
January 2021 % Collaborative	42.1%	42.1%	47.4%	31.6%	47.4%	38.9%	36.8%
January 2021 N	19	19	19	19	19	18	19
July 2021 % Collaborative	47.1%	29.4%	29.4%	37.5%	17.6%	50.0%	35.3%
July 2021 N	17	17	17	16	17	16	17
January 2022 % Collaborative	62.5%	61.1%	55.6%	52.9%	50.0%	47.1%	47.1%
January 2022 N	16	18	18	17	18	17	17

Figure H (continued)

Collaboration Survey: Percent of Coordination and Collaboration Between Agencies

July 2016; Twice per year July 2017 – January 2022

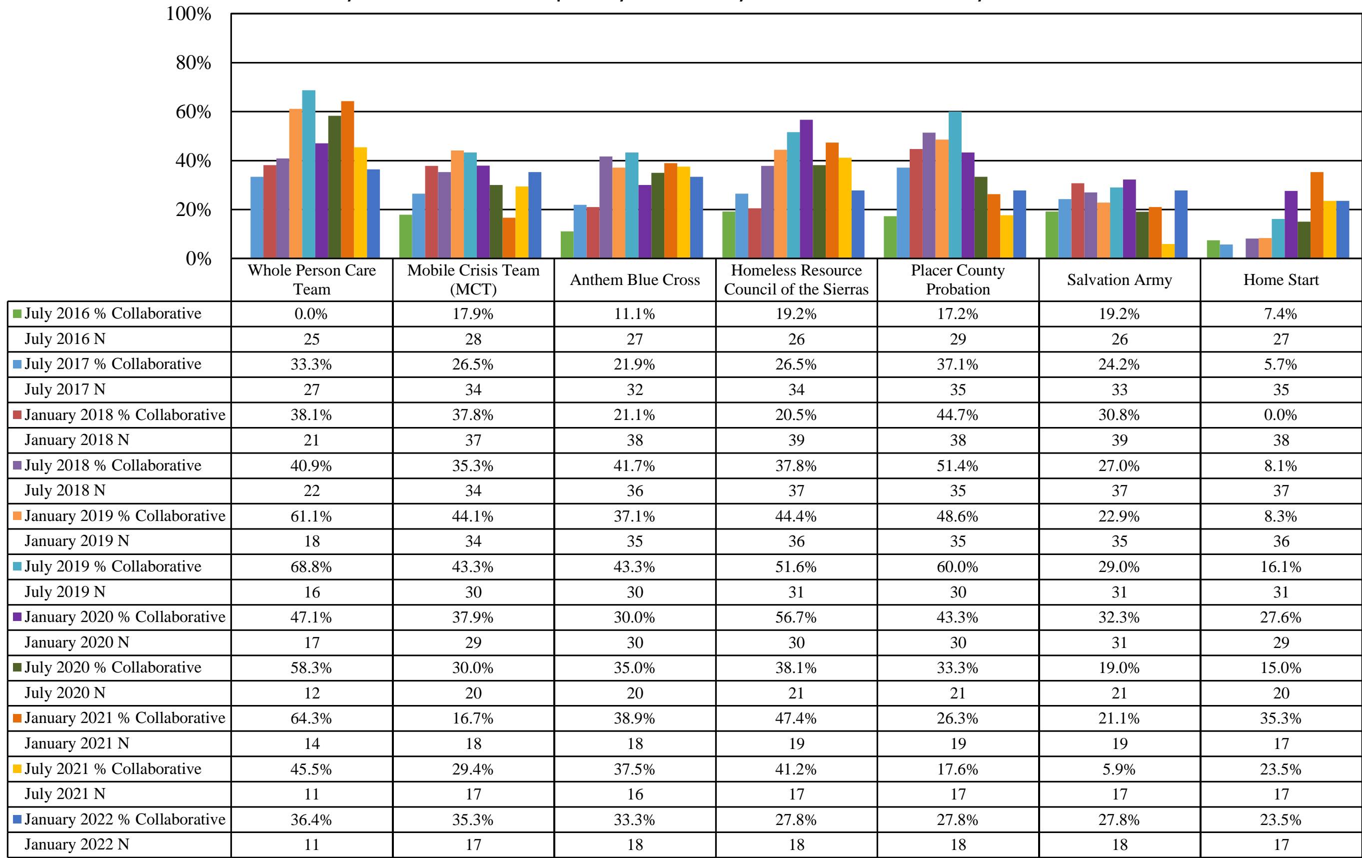


	Advocates for Mentally Ill Housing (AMIH)	Sutter Roseville Emergency Department	Health and Human Services (HHS) Leadership	Gathering Inn	Chapa-De Indian Health	City of Roseville Housing Authority	CA Health and Wellness
July 2016 % Collaborative	24.0%	16.0%	50.0%	30.8%	27.3%	13.8%	23.1%
July 2016 N	25	25	24	26	22	29	26
July 2017 % Collaborative	38.2%	27.3%	66.7%	44.1%	33.3%	20.0%	29.4%
July 2017 N	34	33	30	34	30	35	34
January 2018 % Collaborative	51.4%	25.6%	61.8%	51.4%	29.7%	21.1%	31.6%
January 2018 N	37	39	34	37	37	38	38
July 2018 % Collaborative	61.1%	32.4%	60.0%	50.0%	51.4%	37.8%	44.4%
July 2018 N	36	37	35	36	35	37	36
January 2019 % Collaborative	65.7%	38.9%	63.6%	77.1%	50.0%	45.7%	42.9%
January 2019 N	35	36	33	35	34	35	35
July 2019 % Collaborative	66.7%	48.4%	64.3%	80.0%	60.0%	48.4%	43.3%
July 2019 N	30	31	28	30	30	31	30
January 2020 % Collaborative	56.7%	41.9%	37.0%	66.7%	44.8%	51.6%	36.7%
January 2020 N	30	31	27	30	29	31	30
July 2020 % Collaborative	47.6%	28.6%	60.0%	55.0%	40.0%	23.8%	20.0%
July 2020 N	21	21	20	20	20	21	20
January 2021 % Collaborative	47.4%	47.4%	47.4%	40.0%	22.2%	47.4%	27.8%
January 2021 N	19	19	19	15	18	19	18
July 2021 % Collaborative	41.2%	23.5%	58.8%	42.9%	12.5%	35.3%	41.2%
July 2021 N	17	17	17	14	16	17	17
January 2022 % Collaborative	44.4%	44.4%	43.8%	43.8%	43.8%	41.2%	38.9%
January 2022 N	18	18	16	16	16	17	18

Figure H (continued)

Collaboration Survey: Percent of Coordination and Collaboration Between Agencies

July 2016; Twice per year July 2017 – January 2022



	Whole Person Care Team	Mobile Crisis Team (MCT)	Anthem Blue Cross	Homeless Resource Council of the Sierras	Placer County Probation	Salvation Army	Home Start
July 2016 % Collaborative	0.0%	17.9%	11.1%	19.2%	17.2%	19.2%	7.4%
July 2016 N	25	28	27	26	29	26	27
July 2017 % Collaborative	33.3%	26.5%	21.9%	26.5%	37.1%	24.2%	5.7%
July 2017 N	27	34	32	34	35	33	35
January 2018 % Collaborative	38.1%	37.8%	21.1%	20.5%	44.7%	30.8%	0.0%
January 2018 N	21	37	38	39	38	39	38
July 2018 % Collaborative	40.9%	35.3%	41.7%	37.8%	51.4%	27.0%	8.1%
July 2018 N	22	34	36	37	35	37	37
January 2019 % Collaborative	61.1%	44.1%	37.1%	44.4%	48.6%	22.9%	8.3%
January 2019 N	18	34	35	36	35	35	36
July 2019 % Collaborative	68.8%	43.3%	43.3%	51.6%	60.0%	29.0%	16.1%
July 2019 N	16	30	30	31	30	31	31
January 2020 % Collaborative	47.1%	37.9%	30.0%	56.7%	43.3%	32.3%	27.6%
January 2020 N	17	29	30	30	30	31	29
July 2020 % Collaborative	58.3%	30.0%	35.0%	38.1%	33.3%	19.0%	15.0%
July 2020 N	12	20	20	21	21	21	20
January 2021 % Collaborative	64.3%	16.7%	38.9%	47.4%	26.3%	21.1%	35.3%
January 2021 N	14	18	18	19	19	19	17
July 2021 % Collaborative	45.5%	29.4%	37.5%	41.2%	17.6%	5.9%	23.5%
July 2021 N	11	17	16	17	17	17	17
January 2022 % Collaborative	36.4%	35.3%	33.3%	27.8%	27.8%	27.8%	23.5%
January 2022 N	11	17	18	18	18	18	17

Figure H (continued)

Collaboration Survey: Percent of Coordination and Collaboration Between Agencies

July 2016; Twice per year July 2017 – January 2022

	Community Recovery Resources (CoRR)	Legal Services of Northern California	Stand Up Placer	Western Sierra Medical Clinic	Wellspace Health	Placer Independent Resources Services (PIRS)	Seniors First
July 2016 % Collaborative	14.3%	19.2%	23.1%	7.4%	11.5%	16.0%	26.9%
July 2016 N	28	26	26	27	26	25	26
July 2017 % Collaborative	25.7%	17.6%	26.5%	17.6%	15.2%	21.2%	17.6%
July 2017 N	35	34	34	34	33	33	34
January 2018 % Collaborative	25.6%	10.3%	20.5%	34.2%	18.4%	18.9%	7.7%
January 2018 N	39	39	39	38	38	37	39
July 2018 % Collaborative	33.3%	18.9%	24.3%	37.8%	8.3%	26.5%	18.9%
July 2018 N	36	37	37	37	36	34	37
January 2019 % Collaborative	33.3%	25.7%	25.0%	30.6%	14.7%	22.9%	13.9%
January 2019 N	36	35	36	36	34	35	36
July 2019 % Collaborative	40.0%	35.5%	32.3%	48.4%	23.3%	27.6%	22.6%
July 2019 N	30	31	31	31	30	29	31
January 2020 % Collaborative	32.3%	35.5%	25.8%	16.7%	10.0%	41.4%	19.4%
January 2020 N	31	31	31	30	30	29	31
July 2020 % Collaborative	19.0%	33.3%	19.0%	19.0%	15.0%	26.3%	14.3%
July 2020 N	21	21	21	21	20	19	21
January 2021 % Collaborative	21.1%	36.8%	26.3%	0.0%	5.6%	27.8%	10.5%
January 2021 N	19	19	19	19	18	18	19
July 2021 % Collaborative	17.6%	11.8%	5.9%	0.0%	5.9%	0.0%	29.4%
July 2021 N	17	17	17	17	17	16	17
January 2022 % Collaborative	22.2%	22.2%	22.2%	22.2%	17.6%	17.6%	16.7%
January 2022 N	18	18	18	18	17	17	18

Figure H (continued)

Collaboration Survey: Percent of Coordination and Collaboration Between Agencies

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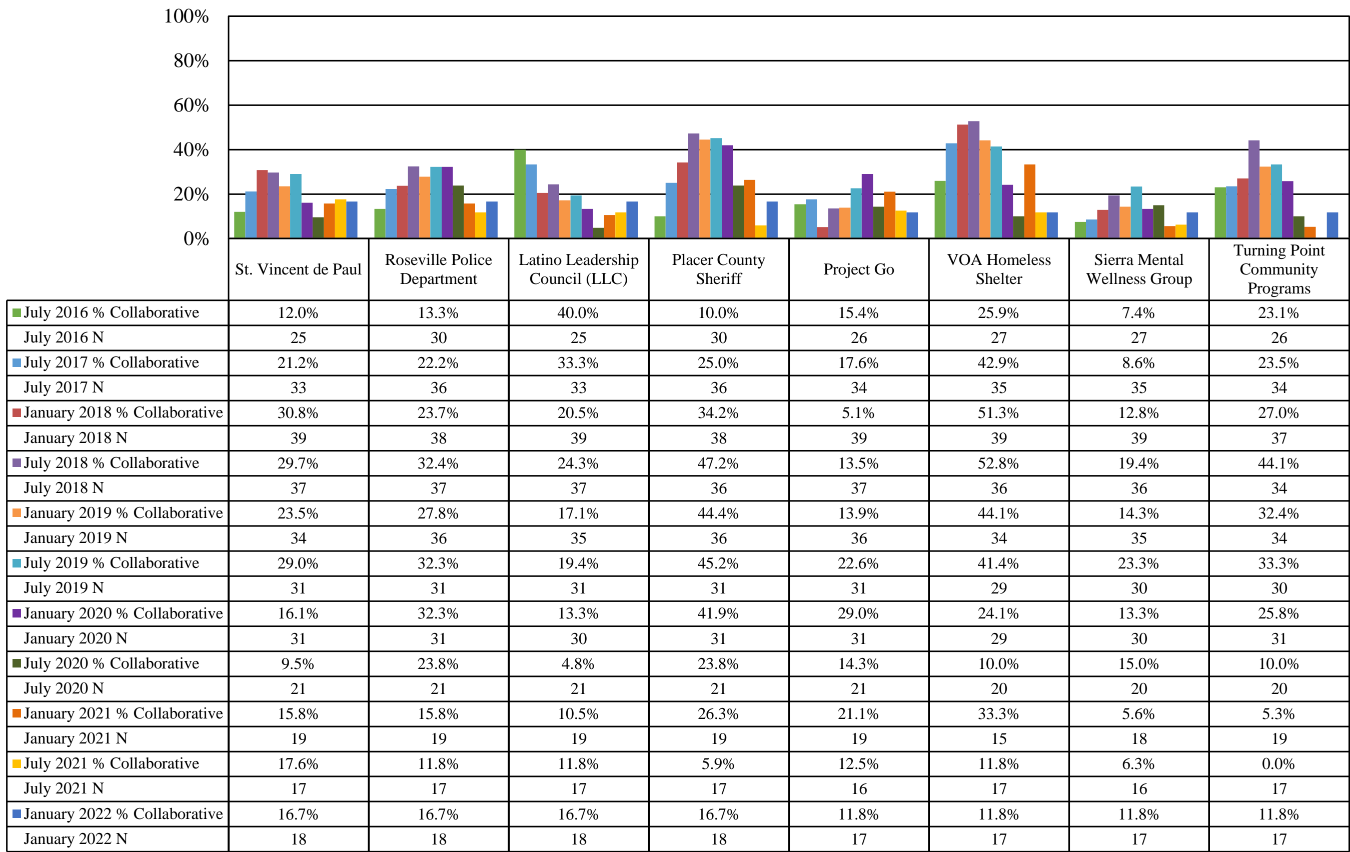
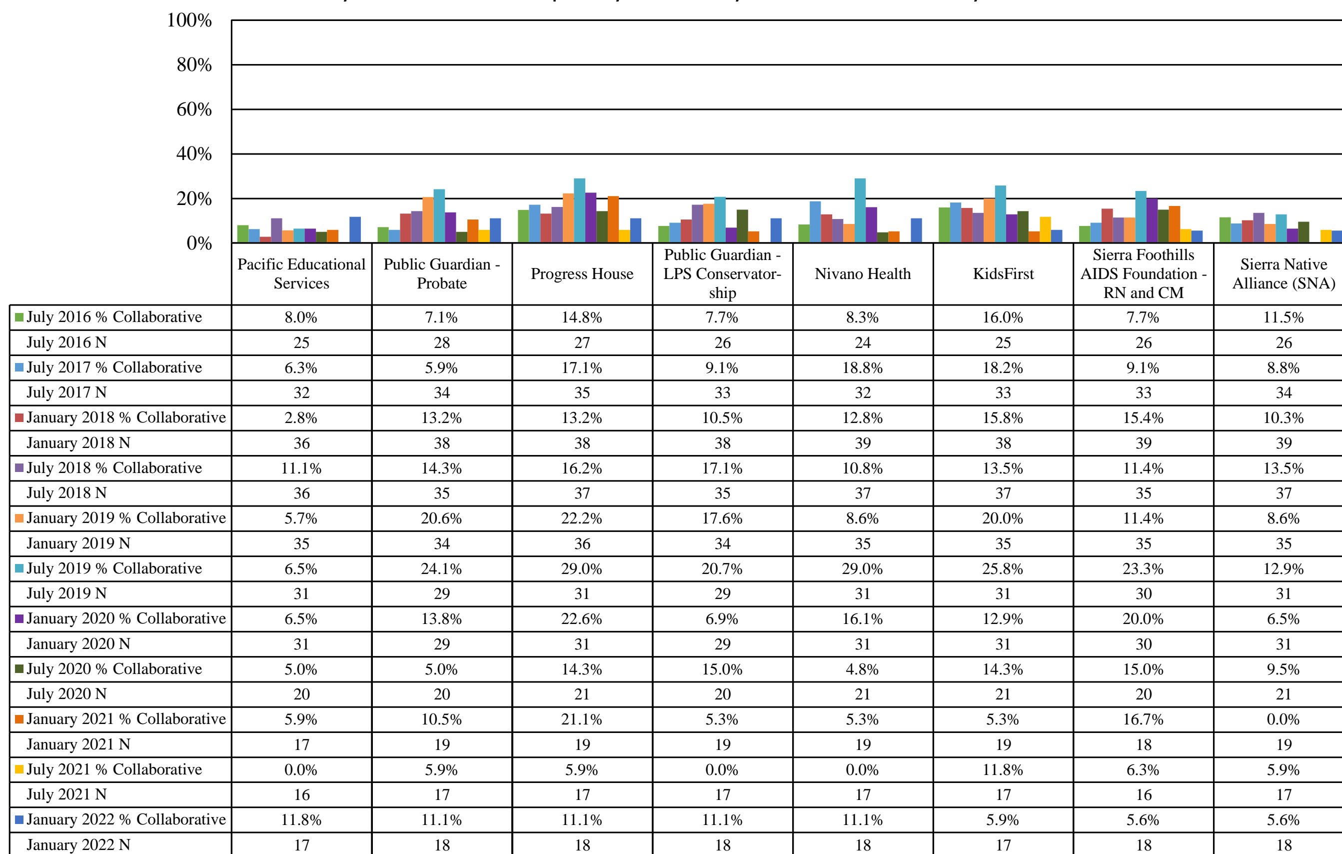


	St. Vincent de Paul	Roseville Police Department	Latino Leadership Council (LLC)	Placer County Sheriff	Project Go	VOA Homeless Shelter	Sierra Mental Wellness Group	Turning Point Community Programs
July 2016 % Collaborative	12.0%	13.3%	40.0%	10.0%	15.4%	25.9%	7.4%	23.1%
July 2016 N	25	30	25	30	26	27	27	26
July 2017 % Collaborative	21.2%	22.2%	33.3%	25.0%	17.6%	42.9%	8.6%	23.5%
July 2017 N	33	36	33	36	34	35	35	34
January 2018 % Collaborative	30.8%	23.7%	20.5%	34.2%	5.1%	51.3%	12.8%	27.0%
January 2018 N	39	38	39	38	39	39	39	37
July 2018 % Collaborative	29.7%	32.4%	24.3%	47.2%	13.5%	52.8%	19.4%	44.1%
July 2018 N	37	37	37	36	37	36	36	34
January 2019 % Collaborative	23.5%	27.8%	17.1%	44.4%	13.9%	44.1%	14.3%	32.4%
January 2019 N	34	36	35	36	36	34	35	34
July 2019 % Collaborative	29.0%	32.3%	19.4%	45.2%	22.6%	41.4%	23.3%	33.3%
July 2019 N	31	31	31	31	31	29	30	30
January 2020 % Collaborative	16.1%	32.3%	13.3%	41.9%	29.0%	24.1%	13.3%	25.8%
January 2020 N	31	31	30	31	31	29	30	31
July 2020 % Collaborative	9.5%	23.8%	4.8%	23.8%	14.3%	10.0%	15.0%	10.0%
July 2020 N	21	21	21	21	21	20	20	20
January 2021 % Collaborative	15.8%	15.8%	10.5%	26.3%	21.1%	33.3%	5.6%	5.3%
January 2021 N	19	19	19	19	19	15	18	19
July 2021 % Collaborative	17.6%	11.8%	11.8%	5.9%	12.5%	11.8%	6.3%	0.0%
July 2021 N	17	17	17	17	16	17	16	17
January 2022 % Collaborative	16.7%	16.7%	16.7%	16.7%	11.8%	11.8%	11.8%	11.8%
January 2022 N	18	18	18	18	17	17	17	17

Figure H (continued)

Collaboration Survey: Percent of Coordination and Collaboration Between Agencies

July 2016; Twice per year July 2017 – January 2022



	Pacific Educational Services	Public Guardian - Probate	Progress House	Public Guardian - LPS Conservator-ship	Nivano Health	KidsFirst	Sierra Foothills AIDS Foundation - RN and CM	Sierra Native Alliance (SNA)
July 2016 % Collaborative	8.0%	7.1%	14.8%	7.7%	8.3%	16.0%	7.7%	11.5%
July 2016 N	25	28	27	26	24	25	26	26
July 2017 % Collaborative	6.3%	5.9%	17.1%	9.1%	18.8%	18.2%	9.1%	8.8%
July 2017 N	32	34	35	33	32	33	33	34
January 2018 % Collaborative	2.8%	13.2%	13.2%	10.5%	12.8%	15.8%	15.4%	10.3%
January 2018 N	36	38	38	38	39	38	39	39
July 2018 % Collaborative	11.1%	14.3%	16.2%	17.1%	10.8%	13.5%	11.4%	13.5%
July 2018 N	36	35	37	35	37	37	35	37
January 2019 % Collaborative	5.7%	20.6%	22.2%	17.6%	8.6%	20.0%	11.4%	8.6%
January 2019 N	35	34	36	34	35	35	35	35
July 2019 % Collaborative	6.5%	24.1%	29.0%	20.7%	29.0%	25.8%	23.3%	12.9%
July 2019 N	31	29	31	29	31	31	30	31
January 2020 % Collaborative	6.5%	13.8%	22.6%	6.9%	16.1%	12.9%	20.0%	6.5%
January 2020 N	31	29	31	29	31	31	30	31
July 2020 % Collaborative	5.0%	5.0%	14.3%	15.0%	4.8%	14.3%	15.0%	9.5%
July 2020 N	20	20	21	20	21	21	20	21
January 2021 % Collaborative	5.9%	10.5%	21.1%	5.3%	5.3%	5.3%	16.7%	0.0%
January 2021 N	17	19	19	19	19	19	18	19
July 2021 % Collaborative	0.0%	5.9%	5.9%	0.0%	0.0%	11.8%	6.3%	5.9%
July 2021 N	16	17	17	17	17	17	16	17
January 2022 % Collaborative	11.8%	11.1%	11.1%	11.1%	11.1%	5.9%	5.6%	5.6%
January 2022 N	17	18	18	18	18	17	18	18

As the WPC team and HICCE worked with the health plans to receive current and baseline data on members, the WPC team also encouraged them to refer individuals who had the highest ED use to WPC. California Health and Wellness consistently referred individuals to WPC. The WPC team also scheduled regular case management consultation phone meetings with Anthem Blue Cross and California Health and Wellness in order to effectively collaborate on member care. As Placer County continued to build and strengthen collaborative partnerships regarding information sharing between multiple systems, the system continued to strengthen services, improve health outcomes, and reduce costs.

Across the years, the collaboration between Behavioral Health and the hospital continued to strengthen. With the implementation of Pre-Manage and being able to identify when clients were admitted to the Emergency Department and/or the hospital and Behavioral Health receiving an immediate notification of the admission strengthened the coordination of services and collaboration across staff. This also helped to build strong relationships and trust between agencies to create positive outcomes for clients and reduce costs. In addition,

COVID-19 also had an impact on the surveys in the last two years as more people worked remotely and some positions on the team were not filled when staff moved to other positions, knowing the project was ending.

5. **Whether and how the County will continue the INN Project; the source of ongoing funding, if applicable; the reason for the decision; and how the County involved stakeholders in the decision.**

The core values of the INN project have been implemented throughout the ASOC. The Pre-Manage software is now being used throughout the ASOC. The staff are transitioning to the Community Supports team and will continue to implement the skills and models that have been so effective with the INN project. While staff will have higher caseloads, the team will continue to implement lessons learned. This approach includes continuing to deliver case management and utilizing strategies learned from the housing programs and specialists on the team.

The Medical Respite program will continue through a contract with the Health Plans in the county, so services will continue in the community. Stakeholders have been involved in the planning and implementation process throughout the project and moving forward with the new system of care services.

6. **Whether the INN Project achieved its intended outcomes; and a summary of what was learned.**

The Pre-Manage software was a significant factor in supporting positive outcomes for the members and achieving intended outcomes. Of the 716 ED visits during the entire project, 674 of them had a timely visit within 7 days. This is 94% of all ED visits by members. Early notification when members come into the ED and/or hospital provided important information to the team, so staff could respond to the member as quickly as possible; help de-escalate the situation whenever possible; and follow-up within 7 days with the member in the community after the crisis to ensure services and supports were available in a timely manner.

The housing coordinator and housing support services, including flex funds also helped to achieve the intended outcomes. These housing services were critical to support these high-need members who are extremely difficult to place in housing, to find housing. During the WPC/HICCE project, staff added six (6) houses with 37 rooms. A total of 187 members were housed. The housing component was also supported by a donation from Sutter Hospital ($2 million) and an additional housing allocation ($1.4 million) from the state.

The Medical Respite was also a very successful program for meeting the needs of members who were homeless, had mental health and/or substance use issues, had significant physical health issues. Without a home, electricity, and running water, it is difficult if not impossible to care for physical health problems. The Medical Respite program provided a safe, clean, environment to help the member learn how to manage their physical health problems; care for wounds and learn how to take prescribed medications. The Gathering Inn Medical Respite provider also had good collaboration with the WPC/HICCE staff to help resolve issues and help get members housed.

WPC with the HICCE Innovation has met and/or exceeded all of the required metrics outlined in the original WPC application. Members achieved intended outcomes, and this program has been recognized as a very successful WPC program across the state. The state and other WPC communities continue to reach out and want feedback regarding the WPC and Community supports related activities.

7. **Description of how the County disseminated the results of the INN Project to stakeholders, and if applicable to other counties (e.g., as the County determined that the information would be of benefit to other counties).**

The WPC/HICCE team reports; shared collaboration surveys in meetings; produced video success stories of members; produced podcasts of members in the program; and provided ongoing consultation to the state and other WPC counties to help support the goals of the projects. All activities and outcomes of WPC/HICCE were periodically shared with the Campaign for Community Wellness (CCW), Placer County MHSA Stakeholder organization.

8. **Any other data or information the County considers relevant.**

The link to WPC podcasts and personal stories:
https://www.placer.ca.gov/2972/Whole-Person-Care-WPC

NOTE: Include a copy of any presentations, reports, articles, manuals, CDs, DVDs, videos, or any other materials developed to communicate successful new or changed mental health practices, lessons learned, and evaluation results of the INN Project.