SACRAMENTO WHOLE PERSON CARE:
STEERING COMMITTEE MEETING – AUGUST 11TH

AGENDA

- Welcoming Remarks
- Introductions
- Overview of Sacramento Whole Person Care
- Steering Committee Role & Responsibilities
- Next Steps & Upcoming Dates

OVERVIEW OF SACRAMENTO WHOLE PERSON CARE

- Program Overview & Objectives
- Discussion of Mission & Vision
- Preview of Service Delivery Model

THE BIG PICTURE

- Four-year pilot program authorized by CMS and administered by DHCS for high-risk Medi-Cal beneficiaries who are frequent users of multiple care systems and have poor health outcomes
- Provides flexible federal funding to improve health and housing outcomes and more efficiently and effectively use health care resources
- Pilots identify target populations, assess health and housing needs, coordinate care in real-time, and evaluate outcomes
- Promotes deeper collaboration and coordination between service providers by requiring pilots to form partnerships and share data

SACRAMENTO'S TARGET POPULATION

Medi-Cal enrolled or eligible individuals experiencing homelessness or at risk of homelessness who are:

- Individuals with complex health care needs
- Frequent users of emergency services and the crisis health system
- The most vulnerable and unsheltered
- High-risk individuals exiting institutions

KEY OBJECTIVES FOR SACRAMENTO'S PROGRAM

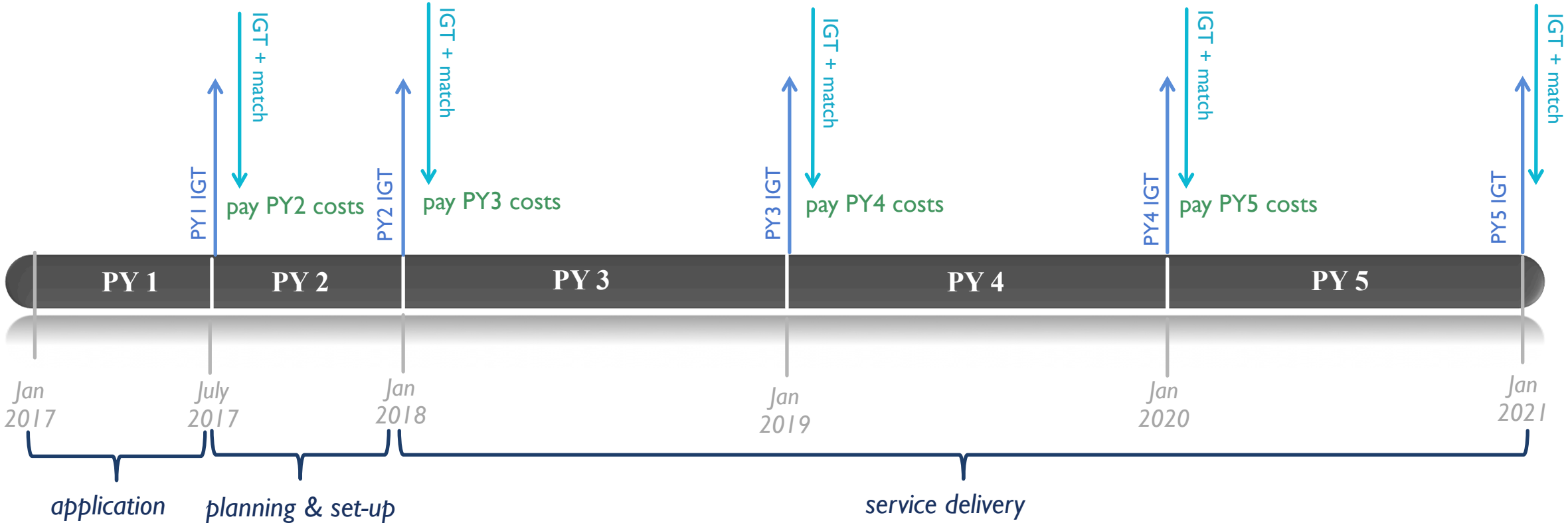
Align	Align Whole Person Care with the City of Sacramento's commitment to moving 2,000 individuals experiencing homelessness from the streets to housing by 2020
Integrate	Integrate the systems of care serving high-risk, high-utilizing homeless populations through care coordination and data-sharing
Achieve	Achieve performance outcomes, including a reduction in unnecessary use of emergency rooms and avoidable hospital stays
Improve	Improve the health and quality of life for individuals experiencing homelessness

FUNDING

- **Whole Person Care is an incentive program** – funding is provided after deliverables are completed
- Deliverables include **providing services** to the identified number of Medi-Cal clients, **reporting metrics**, and **achieving outcomes**
- As the lead entity for the program, **the City must report progress on deliverables** to the state annually and semi-annually to receive funding
- **Funding is provided at the start of each program planning year** for deliverables completed the prior program planning year

FLOW OF FUNDS

IGT funding from prior program year pays for services delivered in current program year



HOW PARTNERS RECEIVE PAYMENTS

- **Service Delivery** – Partner service providers receive payments through the provision of Whole Person Care program services
- **Incentive Payments** – Funds earned through engagement, completion of incentive and by meeting incentive threshold
- **Alignment** – Partners receive payments by agreeing to and providing documentation of alignment of policies and procedures with the Whole Person Care program

AVAILABLE INCENTIVES

- Governance participation
- Universal screening tool development and adoption
- Universal consent form development and adoption
- Development and integration of clinical protocols, policies, and procedures
- Active involvement in barrier identification and resolution
- Support of referral target list development
- Data sharing (planning & adoption)

PERFORMANCE MEASURES

The collective success of partners in achieving performance outcomes is critical to drawing down the maximum amount of Whole Person Care funding.

Key performance measures include:

- **Hospitalizations:** ED visits, inpatient utilization, 30-day readmissions
  - ✓ 15% decrease by 2020
- **Behavioral Health:** Follow-up after mental illness hospitalization, start AOD treatment
  - ✓ 15% increase by 2020
- **Housing:** Connection to permanent housing, referral to housing services
  - ✓ 15% increase by 2020

FUNDING TO SUPPORT DATA & METRICS

Whole Person Care provides funding to support:

- Care Management Platform
- Community Resource Database
- Data Analyst Staffing
- Partner Data Sharing Incentives

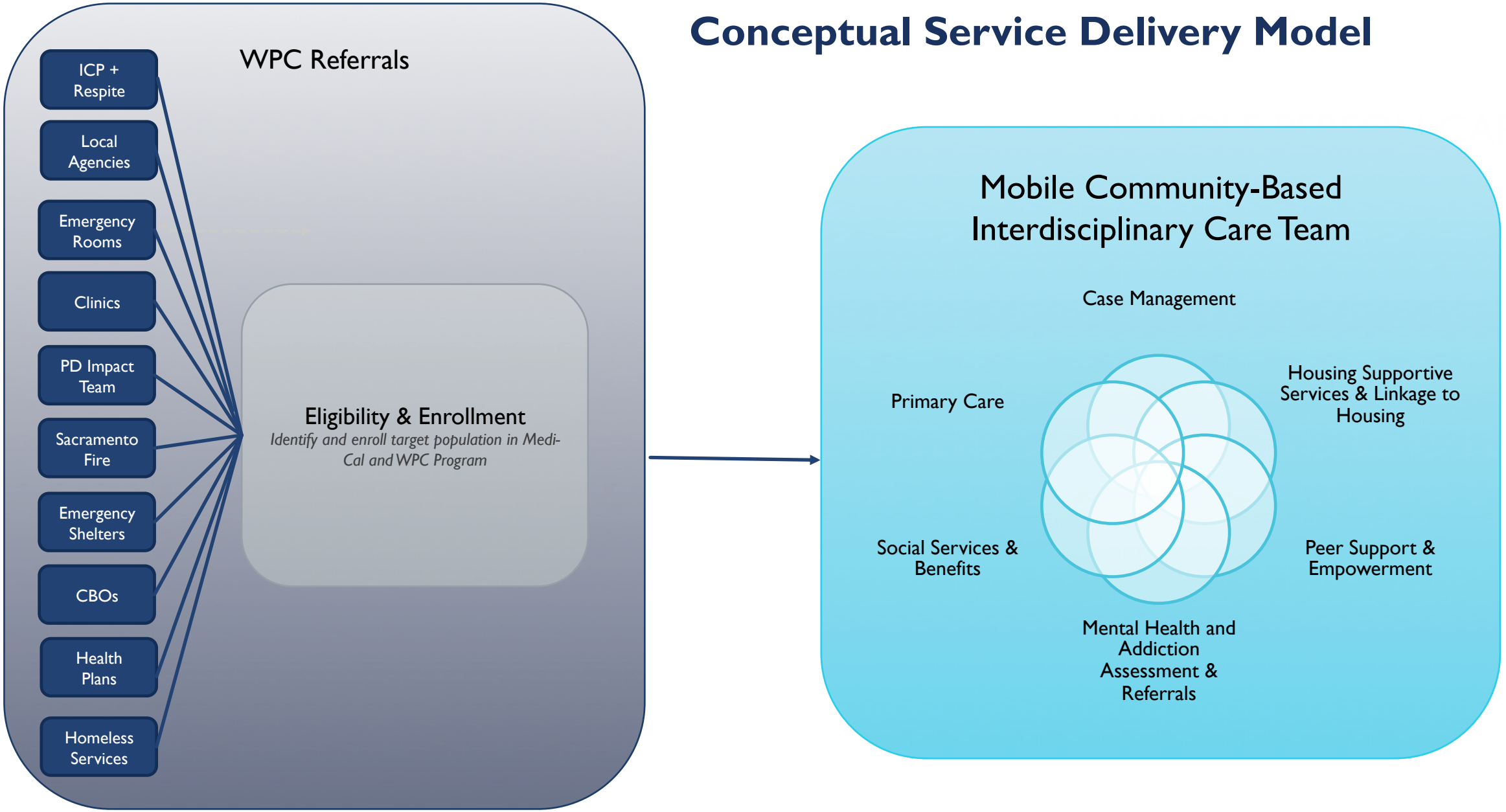
MISSION & VISION: DISCUSSION

1. Review draft Mission and Vision statements in packet
2. Discuss with your table
3. Share feedback and input on worksheet
4. Discuss group comments

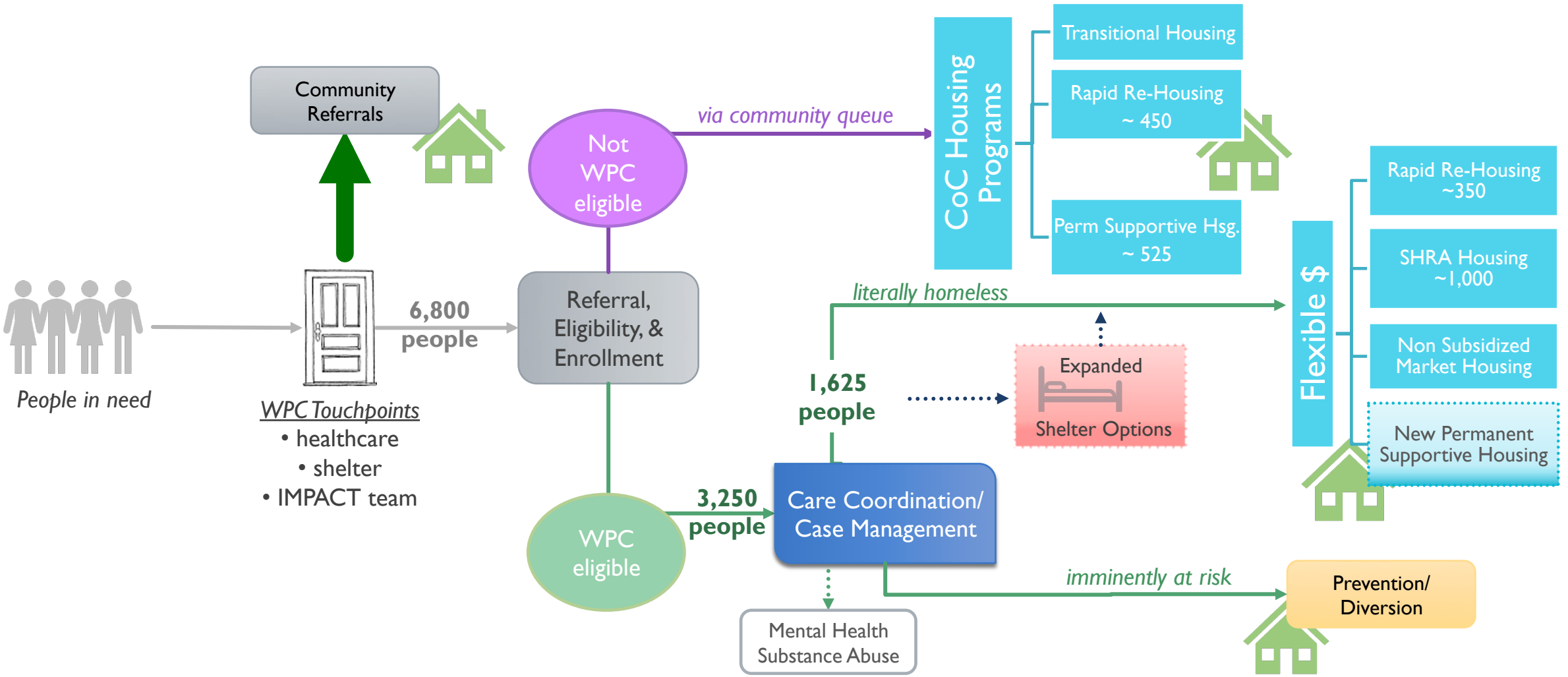
SERVICE DELIVERY MODEL: 5 KEY COMPONENTS

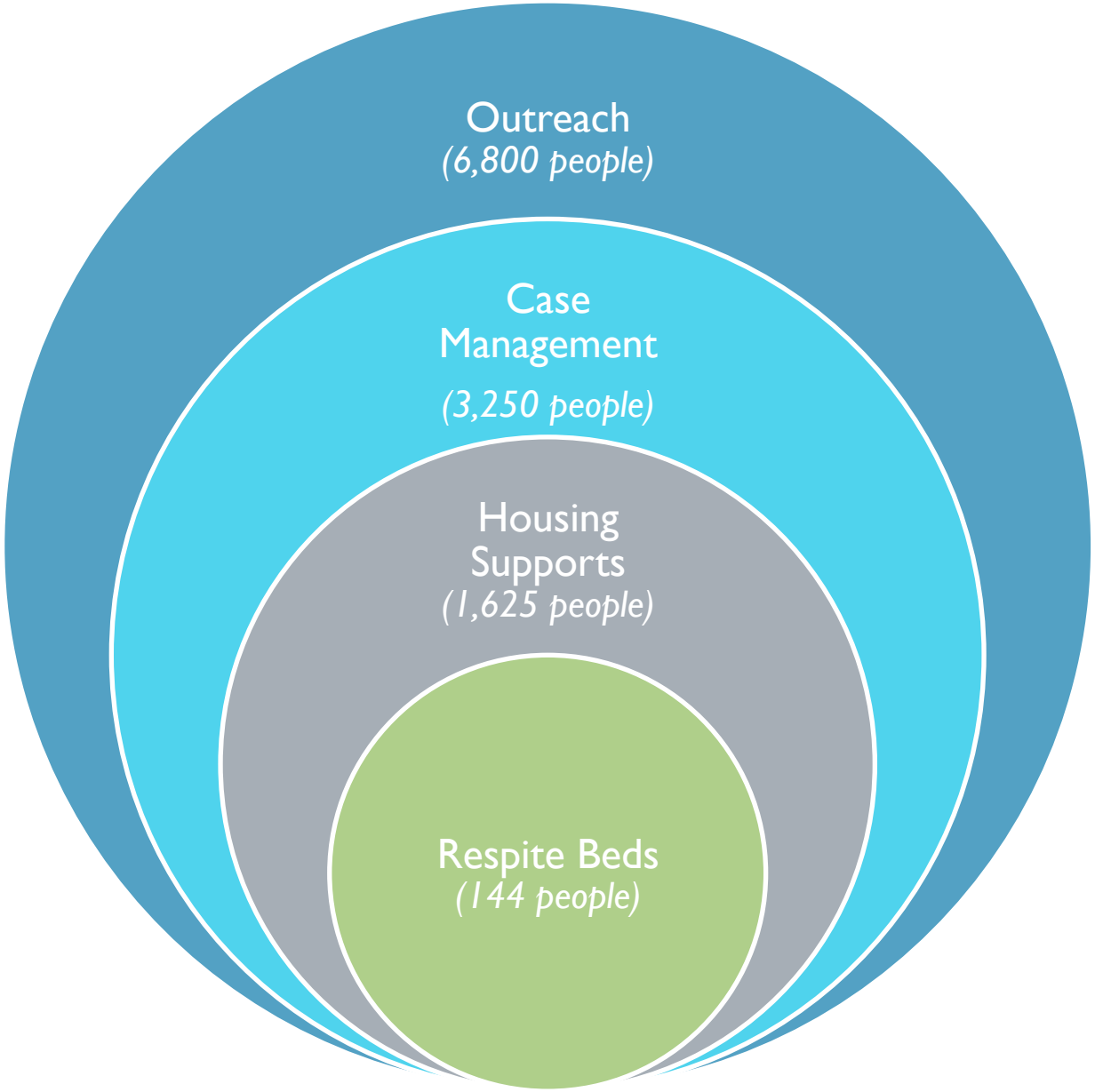
1. Referrals, Enrollment, and Eligibility
2. Mobile Community-Based Interdisciplinary Care Teams
3. Coordinated Access to Health Care, Social Services and Housing
4. Expansion of Sacramento's Housing Capacity
5. Care Management Platform

Conceptual Service Delivery Model



WHOLE PERSON CARE
SERVICE DELIVERY WITHIN THE BROADER SYSTEM



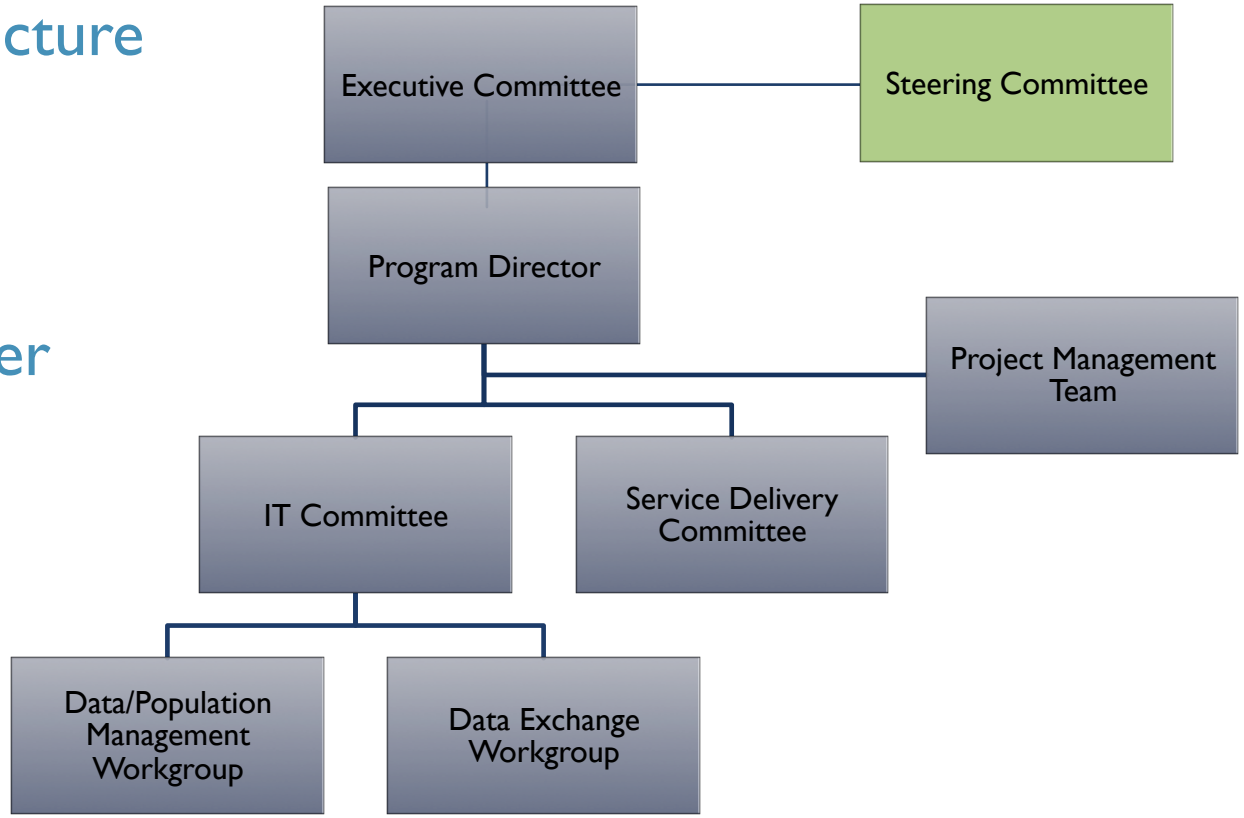


WHOLE PERSON CARE

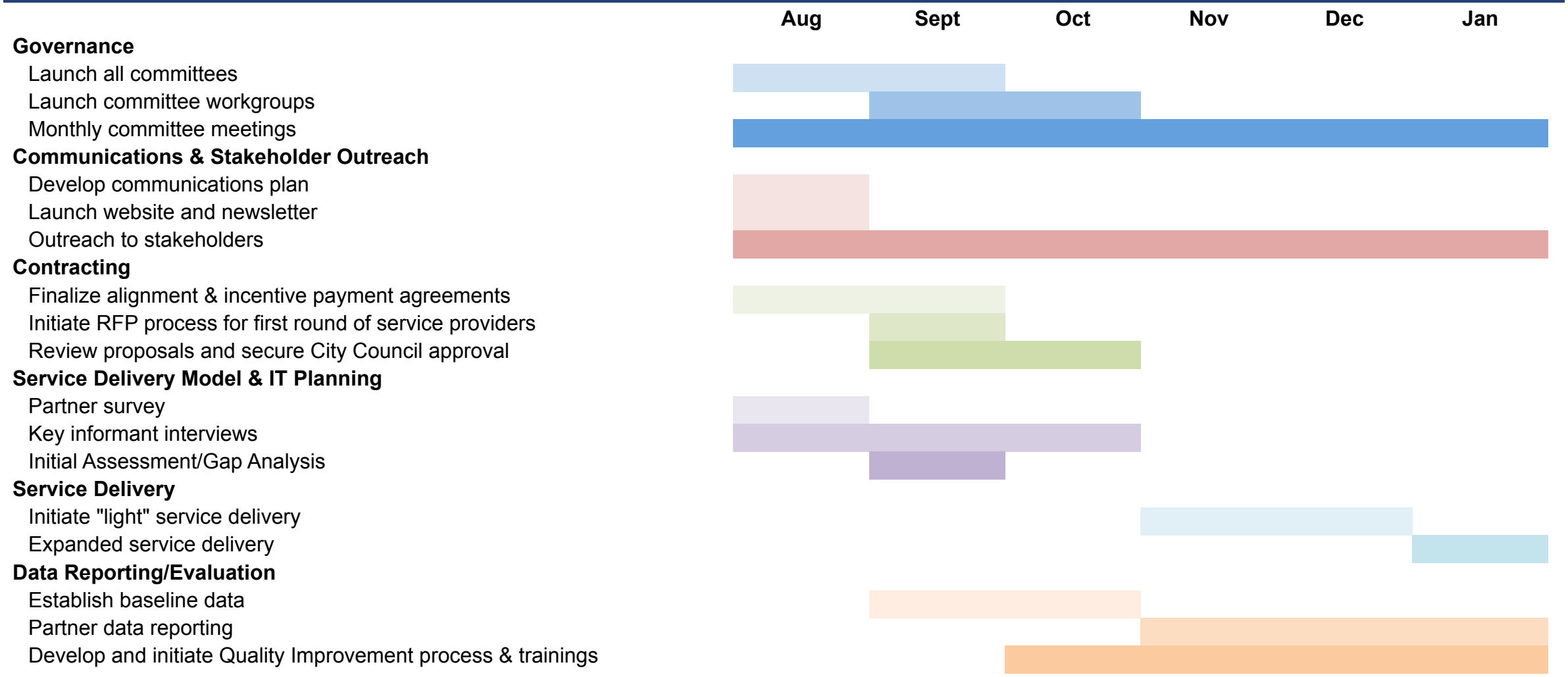
Service Delivery Goals

STEERING COMMITTEE ROLE & RESPONSIBILITIES

- Whole Person Care Governance Structure
- Steering Committee Membership
- Review of Steering Committee Charter
- Comments & Input



KEY DELIVERABLES: NEXT 6 MONTHS



Planning

- *Submit survey*
- *Participate in key informant interviews*

Governance

- *Finalize Steering, Service Delivery, & IT Cmte membership*
- *Attend September 7th meeting*

Implementation

- *Support establishment of baseline data*
- *Review/refine service delivery model*

NEXT STEPS FOR STEERING COMMITTEE