LifeLong Medical Care Trust Clinic

Road to Wellness

ALAMEDA COUNTY HOMELESS POPULATION 01/30/2017 5,629 PEOPLE

- PRIMARY CARE
- SOCIAL WORKER
- HEALTH COACHING
- PSYCHIATRY AND PSYCHO THERAPY
- HOUSING NAVIGATION → Homestretch Applications
- HARM REDUCTION SERVICES → Suboxone Naloxone
- REFERRING PARTNERS → HAC, ROOTS ACHCH, SSI
- GROUPS

PATIENTS • SHARED CARE PLAN • PATIENTS • SHARED CARE PLAN •

- Women's Group • Smoking Cessation • Mindfulness • Exercise & Nutrition • Podiatry
- Men's Group • Art Expression • Acupuncture • Smart Recovery • Medication Education

NOVEMBER 2015 — The Trust Clinic Opens

2016 MARCH — Reimagined Care Program Begins

2016 APRIL — Staff Human Centered Design Workshops

2016 MAY-JUNE — Site Visits to San Francisco and San Diego

2016 SUMMER — Trust Partners Formed

Research Synthesis

Rapid PDSA Experiments

2016 Fall-Dec. — Pitching The Trust Story; More Experiments + Prototypes

2017 Jan-Feb — Pilot Preparation + Assessment

2017 MARCH — Culmination of Human Center Design

JUNE 2017 — Sharing The Trust Story in Washington, D.C.

LifeLong Medical Care
Health Services For All Ages
a california health+ center

Supportive Housing Program

Goals

- Outreach to and engage people experiencing homelessness to achieve stable permanent supportive housing
- Provide accessible health and social services for formerly homeless residents of subsidized housing
- Create opportunities for formerly homeless individuals to achieve improved quality of life

Services Provided

- Outreach/engagement
- Intensive case management
- Housing stabilization/eviction prevention
- Mental health care
- Substance abuse services
- Primary medical care
- Benefits advocacy
- Money management
- Vocational support
- Community building activities

Services are voluntary and confidential. Individualized, intensive case management is provided to those who formally enroll in services, while groups and community activities at housing sites are available to all residents regardless of their engagement level. Access to LifeLong SHP services is limited to those either referred by the funders or to those living at the housing sites. LifeLong identifies housing as a core health issue and practices a harm reduction approach to care. LifeLong provides services on-site in permanent supportive housing buildings and to people living in scattered private apartments paid for through public housing subsidies such as Shelter Plus Care. LifeLong does not own or operate any housing site and does not have prioritized access to units for people who are currently homeless.

Permanent Supportive Housing Sites

LifeLong provides supportive services to formerly homeless, single adults at the permanent housing sites listed below. Services are funded through grants from the City of Berkeley, City of Oakland, HUD, housing owners and LifeLong MediCal revenues. Services provided at the sites and are a collaborative effort involving LifeLong (service provider), housing owners and property management. The model is based on regular communication, joint planning with partners, clearly defined roles and responsibilities, and collaborative decision making. The collaborative team works to address internal issues as well as interacting with funders, neighbors and local government.

Berkeley Permanent Housing Sites

- **University Avenue (UA) Homes, 1040 University Avenue** - a 74 unit single room occupancy hotel
- **Erna P. Harris Court, 1330 University Avenue** - a 35 room single room occupancy hotel

Oakland Permanent Housing Sites

- **Hamilton Apartments – 510 21st Street**, 92 room SRO
- **Dellums Apartments, 644 14th Street**, 68 room SRO
- **The Savoy - 587 15th St**– 84 unit SRO
- **Harrison Hotel – 1450 Harrison Street** – 89 unit SRO
- **California Hotel – 3501 San Pablo Avenue –** 140 unit SRO
- **Clinton Commons – 720 E. 11th Street** – 65 family units
- **1701 MLK – 1701 Martin Luther King –** 26 units
- **The Empyrean, 344 13th St., Oakland, CA 94612**

COACH/Square One

LifeLong, supported by the City of Berkeley and in collaboration with Berkeley Mental Health, conducts street outreach to the chronically homeless in order to connect them to subsidized housing. LifeLong case managers provide supportive services with a focus on finding and maintaining stable housing in the community. Mental health services are provided through Berkeley Mental Health or LifeLong. The projects serve 35 clients.

OPRI (Oakland PATH Re-housing Initiative)/AC Impact

LifeLong, in collaboration with the City of Oakland, ABODE services, Operation Dignity and Alameda County Behavioral Health Care Services conducts outreach to the chronically homeless living in encampments in Oakland in order to connect them to subsidized housing. The LifeLong case managers provide supportive services with a focus on finding and maintaining stable housing in the community. Primary care and mental health services are provided by LifeLong. This project, started in January 2010 serves 90 clients per year.

Project RESPECT – Frequent Users of the Emergency Department

LifeLong community health workers and RNs work with Alta Bates and Summit Hospital ED staff to identify, outreach to and engage with frequent users of the Emergency Department (10 or more visits a year). The majority are chronically homeless ill adults with behavioral health conditions who use the ED for services that are more appropriately provided in community settings. LifeLong provides case management, primary care, mental health, housing assistance, benefits advocacy and transportation assistance. This model shows a consistent 60 – 70% reduction in ED use at two years post enrollment and a 20% reduction in inpatient stays.

Clinical Services Embedded in Community Based Organizations

LifeLong primary care and mental health providers offer clinical services embedded in teams operated by community partners and located at sites in Berkeley and Oakland including:

- Bonita House Inc., HOST program serving seriously mentally ill homeless adults
- Berkeley Food and Housing Project – services provided at the Dwight Way Women's Shelter/Transitional Housing Program and Russell Street Board and Care
- East Bay Community Recovery Program Our Place (HIV/Hep C Care) and Project Pride

Who We Serve

- 73% male, 27% female
- Age range 29 – 74; Average age 52
- 72% African American, 17% White, 4% other
- 90% Medicaid
- 70% on SSI at time of enrollment or within 12 – 24 months
- 89% have a mental health and/or substance abuse diagnosis

Outcomes

For clients living at a supportive housing site or housed in apartments in the community:

- 95% of clients housed have retained housing for at least 12 months
- Less than 4% of residents have been evicted because of non payment of rent
- 75% of residents are enrolled in services
- 100% have identified personal goals as part of a case management care plan
- Over 60% of clients received professional medical or mental health services from on-site staff
- Over 34% of clients participated in vocational or employment-related activities

For frequent users of the ED

- 35% reduction in ED visits for all clients enrolled 12 months. The median reduction in ED visits was 60%
- 40% reduction in ED charges
- 20% reduction in inpatient days and 25% reduction in inpatient admissions

Alameda County Health Care Services Agency
Administration and Indigent Health

Results-Based Accountability (RBA)
Performance Measure Development Worksheet

Organization LifeLong Medical Care
Program Health Care for the Homeless
Goal/Result To Improve the Health and Wellness of Adults Experiencing Complex Health and Social Conditions

Process Objectives	"How Much" Performance Measure	Data Collection Tool	Quality Objective	"How Well" Performance Measure	Data Collection Tool	Impact Objective	"Is anyone better off?" Performance Measure	Data Collection Tool
Primary care health home provides integrated medical and behavioral health care services								
▪ Contractor shall provide integrated primary care services to a minimum of 45 new Trust patients monthly ▪ Contractor shall provide primary care medical and behavioral health services through a minimum of 150 walk-in encounters monthly	▪ # unique patients ▪ # visits ▪ Number of new Trust patients monthly ▪ # walk-in encounters (billable or non-billable) ▪ # active patients (patients with 3 or more face to face visits in 6 months with any Trust team member) ▪ Demographic information	▪ EHR	▪ By June 30, 2019, 50% of patients will have had at least 3 visits within the first six months of the first visit, with at least one being with a primary care provider	▪ % of patients with at least 3 visits on separate dates within the first six months of first visit ▪ % of total patients with at least one health coach, behavioral health and PCP encounter within first three visits	▪ EHR ▪ LifeLong Satisfaction Survey	▪ By June 30, 2019, inpatient/ER utilization of active Trust patients will decrease by 10% from the previous year	▪ Inpatient/ER utilization	▪ EHR ▪ County/ ▪ CHCN Data
▪ By June 30, 2019, 90% of patients who have had at least two Primary Care Provider visits will have been screened for: • Hepatitis C • HIV • Hypertension • Diabetes • Opioid use	▪ % of patients with at least two Primary Care Provider visits who are screened for: • Hep C • HIV • Hypertension • Diabetes • Opioid use disorder		▪ By June 30, 2019, 80% of all patients newly diagnosed or presenting with an existing Hep C diagnosis and two primary care visits will begin treatment	▪ % of all patients identified as Hep C positive who are prescribed treatment		▪ By June 30, 2019, 70% of all patients screened positive for Hep C who complete treatment ▪ By June 30, 2019, 80% of all patients screened positive for Hep C and began treatment are cured of Hep C	▪ % of patients screened positive for Hep C who complete treatment ▪ % of Hep C positive patients with treatment prescribed who have an undetectable viral load	

▪ By June 30, 2019 at least 200 Trust patients will have completed the patient experience survey	▪ # of patients that complete the patient experience survey		▪ By June 30, 2019, 80% of all patients with a positive HIV result will receive treatment ▪ By June 30, 2019, 90% of active patients diagnosed with diabetes will have had their HbA1c measured in a 12 month period ▪ By June 30, 2019, 80% of respondents who completed a quarterly patient experience survey indicate they would refer friends/family to TRUST. (Net Promoter Score)	▪ % of all patients screened positive for HIV who receive treatment ▪ % of active patients with a diabetes diagnosis who have an HbA1c measurement in the past 12 months ▪ % of respondents who completed quarterly patient experience survey who would refer friends/family to TRUST. (Net Promoter Score)		▪ By June 30, 2019, 80% of patients screened positive for HIV who achieve viral control ▪ By June 30, 2019, 80% of active patients with a hypertension diagnosis who achieve blood pressure control ▪ By June 30, 2019, 68% of active patients diagnosed with a diabetes diagnosis achieve diabetes control ▪ By June 30, 2019, 50% of active patients with OUD and evaluated for MAT are prescribed buprenorphine or methadone	▪ after 12 weeks of starting treatment ▪ % of patients screened positive for HIV with an undetectable viral load <20 copies ▪ % of active patients screened positive for hypertension with last SBP <140mm hg and last DBP < 90mm hg ▪ % of active patients screened positive for diabetes who achieve HbA1c control (<9%) ▪ % of active patients with Opioid Use Disorder diagnosis that are prescribed buprenorphine or methadone	
Contractor shall provide Behavioral Health Intakes, complete mental health screenings and address social determinants of health impacting health and wellness.								
▪ By June 30, 2019, 80% of new TRUST patients with at least 2 visits will have a behavioral health intake ▪ By June 30, 2019, 80% of active TRUST patients will have annual: • PHQ-9 • PCL • SBIRT	▪ % of new TRUST patients with a completed behavioral health intake ▪ % of patients with completed annual: ▪ PHQ9 ▪ PCL ▪ SBIRT	▪ EHR	▪ By June 30, 2019, 80% of patients who screen positive for a behavioral health or substance use condition will receive a behavioral health intervention (e.g. brief intervention, counseling, psychiatry services)	▪ % of patients with a positive mental health or substance use screen who receive a behavioral health intervention	▪ EHR	▪ By June 30, 2019, 50% of patients with completed PHQ9 reassessments showed an improvement in their scores	▪ % of patients with positive depression screen who have improved PHQ9 scores	▪ EHR ▪ Housing Specialist Tracking Sheet ▪ County Data

Results-Based Accountability (RBA)
Performance Measure Development Worksheet

▪ By June 30, 2019, 80% of active TRUST patients will have an integrated care plan ▪ By June 30, 2019, 80% of active TRUST patients will have assessments of housing status, income and other social determinants of health.	▪ % of active patients with an integrated care plan ▪ % of active patients who have received Health Coach services ▪ % of patients with income and housing priorities documented in the Case Management Template		▪ By June 30, 2019, 80% of active TRUST patients on a Health Coach panel will have had at least 1 attempted or completed touch per month ▪ By June 30, 2019, 20% of active patients homeless at intake will have an encounter with the Housing Coordinator or housing volunteer	▪ % of active patients with integrated care plan who have documentation of: • housing status • income status ▪ % of patients on Health Coach panel with at least one attempted or completed Health Coach touch per month ▪ % of active patients who are identified as homeless at intake in integrated care plan who meet with the Housing Coordinator or Housing Volunteer		▪ By June 30 2019, 50% of active patients receiving benefits advocacy services are approved for SSI (tracked by AC3) ▪ By June 30, 2019, 80% of patients with Health Coach services received referrals for community based resources ▪ By June 30, 2019, 70% of patients with housing referral specialist services were connected to coordinated entry system	▪ % of active patients receiving benefits advocacy services are approved for SSI (tracked by AC3) ▪ % of patients with Health Coach services referred for community based resources. ▪ % of Housing Referral Specialist patients who completed CES assessment and housing readiness docs	