Health Neighborhood Joint Planning Collaborative

PROJECTS SUMMARY & LESSONS LEARNED

Cross Systems Transformation

HNJPC Partners

- L.A. Care Health Plan
- L.A. County Department of Health Services
- L.A. County Department of Mental Health
- L.A. County Department of Public Health & Substance Abuse Prevention and Control
- Community Clinic Association of Los Angeles County
- Insure the Uninsured Project (Advisory Partner)
- UCLA Center for Behavioral Health Excellence at the Semel Institute (Advisory Partner)

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Blue Shield of California Foundation

IBHP
Integrated Behavioral Health Project

Prepared by Integrated Behavioral Health Project
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Executive Summary

In November 2014, L.A. Care convened the Health Neighborhood Joint Planning Collaborative (HNJPC) and initiated a planning process with the following vision:

> ***One system of unified health, mental health, and substance use disorder care, connected with community and social services, to improve health and well-being of individuals with co-occurring mental health and substance use needs who are experiencing homelessness.***

The goals adopted for this unified system are: 1) coordinate physical health, behavioral health, and other community/social services for adults who are homeless with co-occurring mental health and substance use needs, and Medi-Cal coverage; 2) increase access for this target population; and 3) incorporate services to address relevant social determinant(s).

Planning activities for the HNJPC were organized in four stages: 1) convening a system-level stakeholder steering committee to create a shared vision; 2) selecting a population and geographic focus using high-level need and asset mapping; 3) conducting a neighborhood-specific capacity assessment, including key informant interviews; and 4) analyzing capacity assessment results and developing a systems-level framework to move forward.

Undertaking a project like HNJPC has led to numerous 'lessons learned' that serve to inform next steps, and improve partners' ability to work collaboratively in this and other arenas. The following provides a summary of some of the most salient lessons learned, each of which will inform future work to achieve HNJPC's vision and goals.

- **Understanding the needs of the population:** Understanding the needs and service challenges for individuals experiencing homelessness was instrumental in identifying barriers in the current delivery system. It also helped to create alignment among the HNJPC partners around the shared goal of establishing a tailored delivery model for them, despite different agency priorities, governance, and funding streams.
- **Opportunities and challenges unique to managed care:** Access to health care and exposure to the managed care system are relatively new and confusing for people experiencing homelessness, and to homeless service providers. The new role of managed care plans in the lives of the target population brings high expectations along with real opportunities for improvement. In addition to serving as a convener and leader, L.A. Care has the opportunity to restructure its delivery system to better serve the unique needs of homeless individuals and fundamentally alter the prospect for their improved health status.
- **Alignment of priorities:** Collaborative development to support improved outcomes for a shared population requires explicit alignment of priorities. Sufficient agreement must be gained regarding target population, regional focus, and core system changes. HNJPC partners found it difficult to move from creating a shared vision to making concrete changes to support it, and will focus on those efforts in Year 2.
- **Linkage/coordination in the context of major environmental/policy shifts:** One of the greatest challenges and simultaneously biggest opportunities is operational linkage among partner's related efforts, both planned and/or underway. The unprecedented pace of change post-health reform has divided attention but also promises to add needed physical health, mental health, and

substance use disorder resources for Medi-Cal beneficiaries. Creating meaningful linkages is also quite challenging and remains incomplete for HNJPC.

- **Building local awareness and buy-in/engagement:** From its outset, HNJPC sought to bring a local focus to planning activities, recognizing that programs must reflect local needs, resources, and challenges. While initial learning related to readiness of a given region can be achieved through conversations with key individuals, formal engagement of local stakeholders and leaders is dependent on clear plans and a commitment to resources that will positively impact their local priorities. This commitment is essential because so many agencies "have planning fatigue" and feel they are doing the maximum possible with existing resources.
- **Defining/assessing local 'readiness' and level of need:** Preparing to develop a specialized program in a given geographic area requires learning about the needs of the local target population and the existing capacity (or deficits) to meet those needs. Interviews, conference calls and planning sessions revealed the highly varied levels of readiness and need in four neighborhoods, but were not sufficient to generate a comprehensive assessment in all areas. Comparing and selecting target areas was also difficult because so many communities across Los Angeles with high levels of homelessness and housing instability could benefit from enhanced, integrated health services.
- **Local vs county-wide management support:** Assuring location-specific needs and variables are incorporated into the design and implementation of HNJPC's programs generated important learning. While County agencies have countywide and Service Planning Area-specific staff infrastructure, L.A. Care does not, limiting its current ability to develop regional programs that are responsive to local concerns otherwise missed by countywide approaches.

These lessons, in conjunction with guidance from the HNJPC Steering Committee, are informing and shaping Year 2 of the project. The next set of activities will be focused on formulating the role of managed care plans in improving health outcomes of homeless members. This population-specific managed care delivery system redesign will work to align managed care plans with health service providers, within regulatory opportunities and limitations. Rather than targeting several neighborhoods, the next phase will develop a demonstration of a homeless specialty network with agency partners in a single area before rolling out to other neighborhoods. Long term, the learning and system design associated with the demonstration project are intended to lay the foundation for a countywide, whole health approach that supports individuals experiencing homelessness.

Introduction & Background

The Affordable Care Act (ACA) expanded Medi-Cal coverage to low-income adults without dependent children and created funding opportunities to provide physical and behavioral health services for this vulnerable population. Prior to January 1, 2014, this population relied on a safety net health system designed for episodic care with uneven investment in management across physical and behavioral health sectors. The physical health, mental health, and substance use disorder (SUD) delivery system in L.A. County is complex, with fragmented funding streams and provider networks that are difficult for both patients and providers to navigate. In addition, the safety net health system often fails to address the ways that social determinants of health, such as insufficient affordable housing, affect the health of individuals. As such, outcomes for individuals with complex needs remain poor while associated costs remain disproportionately high.

In summary, while health care coverage has become more accessible, there are still significant challenges in the delivery system for low-income insured and uninsured populations in Los Angeles County. At the same time, the influx of funding related to expanded Medi-Cal coverage offers new opportunities to create a better health system. L.A. Care and its partners sought to take advantage of ACA changes and of existing small scale pilots to create sustainable, scalable changes to improve the health of vulnerable Angelenos experiencing homelessness.

PURPOSE OF THE COLLABORATIVE AND SHARED VISION

L.A. Care Health Plan applied, in conjunction with the L.A. County Departments of Health Services (DHS), Mental Health (DMH), and Public Health – Substance Abuse Prevention and Control (DPH-SAPC) and the Community Clinic Association of L.A. County (CCALAC), for a planning grant from the Blue Shield of California Foundation. The aim was to design locally responsive systems of care for Medi-Cal eligible homeless individuals with co-occurring mental health and substance use needs.

The HNJPC brought stakeholders responsible for providing and paying for care to Medi-Cal and uninsured populations together to identify innovative solutions and build relationships necessary to implement them. Historically, cross sector collaboration within L.A. County has been primarily among County health departments (DHS, DMH, and DPH) and not with health plans. In the past, there have been different levels of collaboration by the County departments and health plans with community clinics, legal entity specialty mental health providers, and SAPC contractors (e.g. through CalMediConnect (CMC), which unifies physical health, mental health, and SUD funding for people with dual Medicare and Medi-Cal benefits). However, creating a collaborative table for all safety net health stakeholders to proactively plan together is relatively new.

The HNJPC selected people experiencing homelessness as a population focus because of their poor health outcomes and high mental health and substance use needs. On any given night in L.A. County, nearly 45,000 people – enough people to fill 937 city buses – do not have a safe and secure place to sleep. This instability results in poor health outcomes, unnecessary trips to the emergency room and rising costs from cycling through an uncoordinated healthcare system. Additionally, the stigma of homelessness and history of institutional mistrust creates significant barriers to care. HNJPC planning efforts focused especially on those who are: chronically homeless, transition age youth, and/or justice-involved individuals.

The HNJPC Steering Committee developed the following shared vision and agreed to work collaboratively toward it:

> ***"One unified system of physical health, mental health, and substance use disorder care, connected with community and social services, to improve the health and well-being of individuals with co-occurring mental health and substance use needs who are experiencing homelessness."***

[1.] LA County Homeless Count 2015: http://www.lahsa.org/homelesscount_results

WHAT IS A HEALTH NEIGHBORHOOD?

Homeless-focused Health Neighborhoods will serve adult Medi-Cal enrollees who are experiencing homelessness and who have co-occurring mental health and substance use needs, with the aim of improving their total health and social well-being. In partnership with local providers serving the same shared clients and populations, homeless-focused health neighborhoods will create structured linkages to community and social services that could include colocation, coordination and collaboration to deliver integrated physical health, mental health and substance use services, in collaboration with homeless services.

COLLABORATIVE PARTNERS

The following chart provides a brief description of each of the HNJPC partners. Insure the Uninsured Project (ITUP) and the UCLA Behavioral Health Center of Excellence at the Semel Institute (UCLA) participated in Steering Committee meetings in an advisory capacity.

L.A. Care Health Plan

L.A. Care Health Plan (L.A. Care) is the largest public health plan in the nation and serves over 1.8 million members across Los Angeles County. Through its network of more than 11,000 qualified physicians, hospitals, clinics and other health care professionals, L.A. Care is one of two plans financially and administratively responsible for arranging medical and non-specialty behavioral health care services for the Los Angeles County Medi-Cal population.

LA County Department of Health Services (DHS)

DHS is the second largest public health care system in the US. Through its integrated network of 20 community-based clinics and four hospitals, DHS treats over 800,000 unique patients a year, employs more than 20,000 staff, and has an annual operating budget of $4 billion.

LA County Department of Mental Health (DMH)

DMH provides specialty mental health services for individuals with Medi-Cal, Medicare, other health coverage, and the uninsured. DMH has more than 125 contracted legal entities, and 24 directly operated programs at 36 sites.

LA County Department of Public Health (DPH) *Planning & Substance Abuse Prevention and Control (SAPC)*

DPH protects health, prevents disease, and promotes the health and well-being for all persons in Los Angeles County. DPH's focus is on the population as a whole, and conducts activities through a network of public health professionals throughout the community.

DPH-SAPC provides SUD services to both indigent and Medi-Cal populations through its more than 300 contracted agencies and one directly operated facility.

Community Clinic Association of Los Angeles County (CCALAC)

CCALAC supports its 55 member clinics to serve their patients in an efficient and cost-effective manner while providing quality care. The association strives to identify and address the collective needs of our members at the local, state and federal levels. CCALAC delivers a variety of member services including policy advocacy, education, and peer support. It connects clinics, shares and leverages resources, increases organizational capacity, and raises a unified voice on behalf of clinics.

ADVISOR: Insure the Uninsured Project (ITUP)

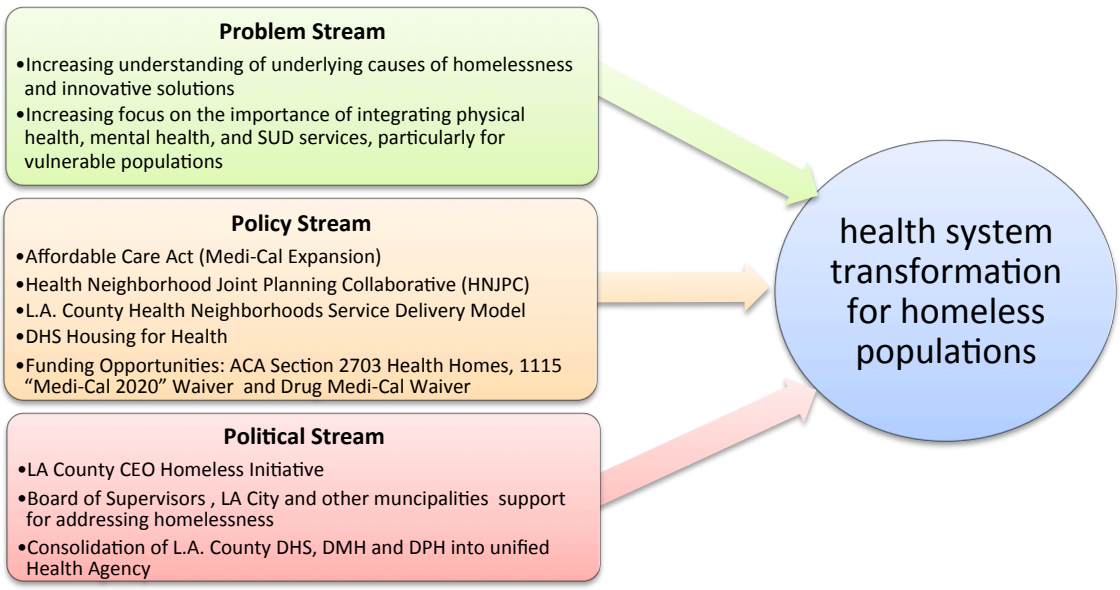
ITUP is a 501(c)(3) nonprofit organization funded by The California Wellness Foundation, The California Endowment, the Blue Shield of California Foundation, the California Community Foundation, Kaiser Permanente, and L.A. Care Health Plan. ITUP identifies, assists, and promotes new approaches to expand health care and coverage for California's uninsured. Founded in 1996, ITUP finds common ground and establishes connections among health care payers and providers to increase coverage of California's uninsured.

ADVISOR: UCLA Behavioral Health Center of Excellence at the Semel Institute

The UCLA Behavioral Health Center of Excellence at the Semel Institute was funded by the Mental Health Services Act and launched in October 2014. The Center provides research, communication, education and outreach programs that address mental health disparity through innovations developed at UCLA's Center for Health Services and Society. The Center is in the midst of a three-year start-up period at the Semel Institute. The program is designed to enhance the California Mental Health Services Act by executing rapid sharing of innovative research in California, as well as evidence based practices already tested in the University of California.

RAPIDLY EVOLVING POLICY LANDSCAPE

In the last year, numerous policy changes at the local, state and national level have highlighted the serious problem of homelessness in L.A. County, and the need for physical and behavioral health integration to better serve vulnerable populations. One way to visualize the many moving pieces related to homelessness is through John W. Kingdon's policy window model[2] of public policy change. In order for policy action to address homelessness to get on the agenda, the three streams (problem, policy and political) must be aligned to create an open policy window. As shown below, the **problem stream** must be viewed as a pressing issue requiring action; the **policy stream** must have viable and actionable policy alternatives or solutions and finally the **political stream** requires that politicians and their staff be willing to utilize political capital and allocate necessary funding to implement a policy change. Over the last year, political pressure to effectively address homelessness has been building. The HNJPC will capitalize on this open policy window to implement change and to share these lessons learned with those most able to use the recommendations.



[2] Kingdon, J.W. (2010). Agendas, Alternatives, and Public Policies (2nd Edition). New York: Pearson.

However, it should be noted that while these policy opportunities have led to additional funding and political will for change, they have also resulted in divided attention. As with any planning process, unanticipated changes required project staff to adjust and make modifications to the original project plan. The following section outlines how these policy opportunities have affected the HNJPC planning and implementation process.

Policy Change or Initiative	Impact on the HNJPC
L.A. County Health Neighborhoods Service Delivery Model Development The HNJPC planning effort took place at the same time as implementation of a Health Neighborhood "Service Delivery Model" in seven geographic areas across the County. The goal of the Service Delivery Model project, led by the Department of Mental Health, was to link safety net physical health, mental health, substance use disorder, and public health providers through provider agreements, in order to coordinate care more effectively within the existing infrastructure for health care delivery and funding. The Service Delivery Model is for all shared clients in a geographic area, including all ages and payer sources.	The HNJPC Steering Committee decided to focus on a smaller, high-need population in order to differentiate from the work of the Service Delivery Model Health Neighborhoods. This group decided to build upon the provider relationships that DMH has fostered, with the goal of applying learning about care coordination and integration for people experiencing homelessness to this and other populations in the future.
Consolidation of L.A. County DHS, DMH and DPH into unified Health Agency The health agency consolidation authorized by the L.A. County Board of Supervisors (BOS) in the fall of 2015 unites the Department of Health Services, Department of Mental Health and the Department of Public Health under a single Health Agency. This administrative change is designed to maximize the opportunity created by Medi-Cal expansion to integrate health, mental health, and substance use treatment services with one another and with other services that promote health and stability.[3] This change involved multiple stakeholder meetings over the course of eight months, with testimony from public and community agency leaders who had concerns about the consolidation process.	The changing County department structure created uncertainty about County priorities and the likelihood of other programmatic or operational changes, which in turn prevented the HNJPC from being able to move forward as decisively. Additionally, the creation of the health agency made collaboration more challenging due to changing leadership roles and relationships.
LA County CEO Homeless Initiative The Board of Supervisors (BOS) established the L.A. County CEO Homeless Initiative[4] on June 2, 2015 and tasked them with creating recommendations to decrease homelessness in L.A. County through a holding series of summits. The two summits of greatest relevance to HNJPC were "Affordable Care Act" and "Coordination of Current Services."	Ideally, the L.A. County CEO Homeless initiative will provide a platform for broader dissemination of the HNJPC findings, and prioritization of delivery system changes to improve the health of people experiencing homelessness. The coordinating committee included many of the key leaders already involved in the HNJPC planning process.

[3] Connection between health agency creation and addressing homelessness in LA County: http://priorities.lacounty.gov/homeless-initiative-seizing-the-moment/. Accessed November 11, 2015.

[4] More information on the LA County CEO Homeless Initiative and to review policy briefs: http://priorities.lacounty.gov/homeless/. Accessed November 11, 2015.

Policy Change or Initiative	Impact on the HNJPC
1115 "Medi-Cal 2020" Waiver On October 31, 2015, DHCS and CMS released a conceptual agreement that outlines the major components of California's 1115 Medicaid waiver renewal that will be in effect from 2015-2020. The total initial federal funding in the renewal is $6.218 billion. Proposed programs for behavioral health integration and shelter/housing related services were not included in the final concept. However, the waiver authorizes a Whole Person Care pilot that would be a county-based, voluntary program that could provide more integrated care and nontraditional services for high-risk, vulnerable populations.	The HNJPC goals should be aligned with funding opportunities in the waiver, but may not be a one-to-one match on target population. The whole person care pilot could offer funding for nontraditional Medi-Cal services such as housing supports, which were identified as key needs for the target population.
DMC-ODS Waiver (Drug Medi-Cal Waiver) The Drug Medi-Cal waiver (DMC-ODS) offers the opportunity for additional funding and expansion of covered benefits for SUD services provided through SAPC. New DMC-ODS services will meet American Society of Addiction Medicine criteria and include expanded residential and field capable services.	Access to SUD treatment was consistently identified by HNJPC stakeholders as an essential, unmet need for adults experiencing homelessness, so this should be an important new resource. As L.A. County builds new SUD resources, the HNJPC findings will inform the structure and delivery for people experiencing homelessness.
Health Homes - ACA Section 2703 The Medicaid Health Home State Plan Option, authorized under ACA Section 2703 allows states to create Medicaid health homes to provide supplemental services that coordinate physical health, behavioral health, and community-based long term services and supports. The Health Homes Program (HHP) in California will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are also frequent utilizers, and focus on individuals who are chronically homeless. Many of the details for the health home benefit, such as eligibility, provider contracting, IT and quality reporting systems, and rate setting are still to be decided.	The health home program will increase funding for case management for vulnerable populations, but it is unclear how many individuals experiencing homelessness will be eligible. During the HNJPC planning process, the Steering Committee decided to focus on the needs of the target population, rather than planning around the specifics of the Health Homes funding opportunity.

ACRONYMS

BOS: LA County Board of Supervisors
CCALAC: Community Clinic Association of Los Angeles County
CMS: Centers for Medicare and Medicaid Services
CSH: Corporation for Supportive Housing
DMC-ODS: Drug Medi-Cal Organized Delivery System
LAHSA: Los Angeles Homeless Services Authority
MCO: managed care organization
SAPC: Substance Abuse, Prevention and Control
SUD: Substance Use Disorder

Planning Activities & Methods

The HNJPC project's planning phase (Year 1) was conducted using the following approaches:

1. Convening of a Steering Committee made up of senior managers and staff from each partner agency;
2. Using a behind the scenes "Core Team" to guide specific tasks, support achievement of milestones, and facilitate process learning; and
3. Contracting with Integrated Behavioral Health Project (IBHP) to provide expertise and carry out specific planning activities.

Over the course of the planning year, the HNJPC team worked together to accomplish the following:

- Adoption of Project Charter, including selection of the target population, and a shared vision;
- Evaluation of the need related to homeless individuals, existing capacity, and opportunity in neighborhoods across the County;
- Selection of four neighborhoods to target for initial community engagement and implementation planning;
- Driver diagram to describe key causes of poor health outcomes for homeless individuals, and change concepts to address those drivers and improve their health (see Appendix A for the complete HNJPC Driver Diagram;
- Selection of key stakeholders in each neighborhood and the instrument/questions for their interviews;
- Identification of two options or approaches to work collaboratively to improve health outcomes for homeless individuals – followed by the selection of one option; and
- Overarching implementation plan to act on the selected option.

The activities that supported this planning and decision making occurred in four steps, each of which is described in detail below.

STEP 1: COLLABORATIVE PLANNING PROCESS

Step 1 consisted of convening systems-level stakeholders Steering Committee in a collaborative planning process. Specific tasks were:

- Create a shared vision and guiding principles (building on the Triple Aim, aligning payment with whole person care, uniting revenue streams);
- Adopt short- and long-term strategic goals and objectives;
- Identify priority target populations;
- Identify primary drivers for systems transformation to improve population health:
- Support the planning process by involving experts in the field and reviewing successful models tried in other communities;
- Develop design concept to address systems fragmentation and barriers to care;
  - *At individual level:* improve access and services; implement person centered outreach and engagement strategies; deliver care in appealing ways for easy access; coordinate services

across care continuum; address homelessness / housing as one important social determinant of health;

- *At systems level:* create a seamless system to provide whole person care; shared vision, defined roles and responsibilities; align funding across sectors; redesign safety net infrastructure; align contracting strategies; use technological tools; collect and report data to support quality improvement;

- Gain consensus to move forward through facilitated process; and
- Engage systems' leaders to validate process and proposed outcomes (MCO Chief Operating Officer, County Department Heads).

STEP 2: SELECTING POPULATION AND NEIGHBORHOODS OF FOCUS

Step 2 supported high-level evaluation of communities throughout Los Angeles County in terms of level of need, existing provider capacity, and local initiatives representing synergistic opportunity. Specific tasks were:

- Map 14 communities of highest need for homelessness and housing instability;
- Map health care, mental health, and substance use disorder facilities as a measure of regional readiness in those communities;
- Rank the order of areas of highest need to assist with the target neighborhood selection process;
- Recommend eight areas that appeared to have provider capacity with potential to transform services for target population;
- Narrow target neighborhood selection to four broad regions for further study;
- Select four neighborhood geographies that are prioritized by DMH health neighborhood initiative that aligns health, mental health and substance use disorder providers; and
- Map homeless population census tract data from Point in Time Count obtained by Los Angeles Homeless Services Authority conducted in January, 2015.

STEP 3: NEIGHBORHOOD-SPECIFIC CAPACITY ASSESSMENT AND PLANNING

Step 3 was focused on preparing for and conducting Key Informant (KI) interviews in each of the four targeted neighborhoods, followed by initial planning for implementation in each. These interviews had the two-fold objective of gaining information to inform future implementation planning and beginning stakeholder engagement critical to that planning. Tasks included:

- Identify potential leaders for conducting KIs, by selected geography and health sector;
- Develop standard KI guide;
- Conduct KIs as a team (health plan staff and IBHP facilitators);
- Summarize KI findings into slide presentation for Steering Committee;
- Identify key additional leaders, regional service gaps and priorities for service augmentation;
- Validate planning process, vision, guiding principles with KI; and
- Assess regional interest in pursuing planning process and systems transformation.

Also part of Step 3 was analysis of findings and formulation of recommended action. Specific tasked included:

- Synthesize KI findings into high level presentation;
- Identify cross cutting themes, challenges, priorities, provider capacity, assets and strengths;
- Identify unique regional challenges, assets, priorities, region/capacity to engage in systems change for target population;
- Rank order areas for action by geography;
- Present findings to Steering Committee to validate recommendations; and
- Modify project plan to incorporate Steering Committee priority regions (e.g. revise neighborhood boundaries).

Formulating the KI findings with the Driver Diagram and other Step 1 activities into initial implementation plans also took place during Step 3. Specific tasks included:

- Initiate development of regional implementation plans to improve services for target populations (incomplete based on decision to focus on managed care system changes first and one demonstration region)
- Convene regional stakeholders to present HNJPC, solicit input and refine implementation plan in one neighborhood (Hollywood);
- Attended regional homeless coalition meetings in two areas (Hollywood and San Fernando Valley) to introduce HNJPC, learn more about regional priorities and engage additional leaders for future planning;
- Determine structure and regional leadership to advance transformation action plan for one area (Hollywood); and
- Develop implementation plan for L.A. Care and one individual regional plan (Hollywood) based on KIs, Driver Diagram, and Steering Committee input.

STEP 4: SYSTEMS LEVEL PLANNING

Step 4 represents the initial work of system implementation, and as such, the following tasks were initiated or planned, though many will be completed in Year 2:

- Gain Steering Committee agreement to create a seamless system to support whole person care across physical health, mental health, substance use, and housing;
- Determine health plan role and public agency readiness;
- Lead planning processes with County department and L.A. Care staff to identify department/MCO operational changes, resource deployment and operational policy guidance;
- Support external care transformation with care networks (department/MCO contracts, operational guidance);
- Build County, health plan and stakeholder relationships throughout planning process;
- Validate planning findings with newly established Health Agency department heads and managed care plan leadership;
- Assess managed care health plan resources to support continued planning;
- Determine and advise on managed care resources available to support transformation activities;
- Support managed care plans' role as convener for systems transformation to support whole person care; and
- Prepare for future State and federal initiatives by accelerating decision-making, leadership involvement and adopting action plans.

Lessons Learned

Undertaking a developmental project like HNJPC has led to numerous 'lessons learned' that serve to inform next steps, as well as improve partners' ability to work collaboratively in other arenas. The following provides a summary of the learning themes that emerged as well as the specific learning related to each theme. While this summary is not exhaustive, it does represent the learning that gives direction to the project and that will inform the fundamental change necessary to achieve HNJPC's mission and vision. These are organized into the following over-arching themes:

- Managed Care and High Need Homeless Individuals
- Leadership, Governance & Project Planning
- Challenges & Successes of Partner Collaboration
- Regional Variation & Local Engagement Strategies

MANAGED CARE AND HIGH NEED HOMELESS INDIVIDUALS

Understanding the needs of the population: Gaining a baseline understanding of the needs, challenges and other attributes of the target population proved to be instrumental in establishing an overarching approach to a specialized delivery system for them. Key learning included:

- The complexities of engaging and serving homeless single adults in physical health, mental health, and SUD service settings, and the importance of securing housing as a strategy for client engagement and improving health outcomes.
- The difficulty that homeless individuals and homeless service providers face in navigating the Medi-Cal managed care system. The majority of chronically homeless adults had minimal access to health insurance until 2014, and are unfamiliar with the system.
- The current service gaps that are most relevant to this population: crisis mental health, substance use disorder treatment, mobile outreach and housing.
- The role that homeless coalitions can play to plan and foster systems transformations, and the varied level of health stakeholder involvement in this work.
- The role that the Coordinated Entry System[5] plays to transition homeless persons to housing.

Opportunities and challenges unique to managed care: The planning activities revealed several lessons about the new role of the managed care in organizing health care delivery to high need homeless beneficiaries.

- Health care stakeholders, including physical health, mental health, and SUD providers, are looking to the health plan to improve health services and outcomes. Knowledge about the role and operations of managed care plans varies greatly among safety net health providers – even health providers who are contracted with the managed care plan.
- Homeless service providers want to understand the health plan's roles and responsibilities for care management of single adult homeless individuals. Expectations are high that the health plan can solve some of the chronic shortages in the homeless services continuum, such as 1) housing navigation and Skilled Nursing Facility placement; 2) improved transitions from hospital to community services; 3) improved relationships between hospitals and homeless service providers; 4) access to mental health and substance use services; and 5) supportive services for housing retention.

[5] CES is a no-wrong door, countywide system that engages and connects single adults experiencing homelessness to the optimal resource for their needs. http://ceslosangeles.weebly.com/

- Homeless service providers operate outside the existing Medi-Cal system. L.A. Care would need a new contracting strategy and provider certification process if it chooses to include these providers in its future contracted network. These agencies are not likely to fit into existing provider categories or credentialing requirements, nor are they likely to have a managed-care friendly fee structure in place for their services and supports.
- The health plan has a key role to play because it is legally, financially and clinically responsible for its homeless adult members' care. It has infrastructure capacity to assist with member assignment, a 24/7 nurse advice line and care management team, and linkage to Long Term Services and Supports. It has the ability to build a narrow, specialized homeless member network (as opposed to random assignment to any primary care provider) to address the complex problems homeless individuals face. It holds the purse strings for medical groups, hospitals and risk pools and so has the ability to set pay for performance goals, quality and access standards, conduct quality improvement, sponsor specialized training and provider support.
- As a managed care plan, L.A. Care has the ability to create a narrow specialized contracted network for the target population. A specialty program (e.g. health plan member assignment to a specialized health home, strategies for identifying future homeless members at the point of enrollment and communication with the health plan) may require State Department of Managed Care Services approval of elements of the care model, outreach and engagement activities, and other unique aspects of the emerging specialty network.

LEADERSHIP, GOVERNANCE & PROJECT PLANNING

Role of managed care plan as lead vs. county agencies or others: HNJPC was undertaken by L.A. Care on behalf of key L.A. County health care stakeholders committed to improving safety net health systems and integration. This structure led to many insights about the unique role of a managed care plan in a collaborative project like HNJPC:

- Having a health plan lead the planning effort had advantages: 1) the health plan controls the physical health purse strings; and 2) stakeholders came to the planning table because of the perception that the health plan can allocate new resources to services delivery.
- Having a health plan lead the planning effort also had disadvantages: 1) Los Angeles is a two plan Medi-Cal model with additional plan partners, meaning multiple health plan stakeholders (a County Organized Health System might have had a more streamlined planning process); 2) L.A. Care has a delegated managed care model, with less control over service delivery and need for buy in from medical groups to create specialized models; and 3) the health plan has limited ability to identify homeless beneficiaries.
- Managed care will continue to drive health systems transformation and payment reform over the coming years, meaning that the financial security and operational performance of the County operated and contracted systems are intricately intertwined with L.A. Care. For example, funding provided through the 1115 Waiver, Drug Medi-Cal waiver and ACA 2703 Health Home all create different possibilities for more integrated and coordinated care.
- L.A. Care has a potentially unique role to play as a neutral convener, but needs to clarify its leadership role. Initially, L.A. Care acted as the caretaker of the grant work plan and sought to support DMH's Health Neighborhood Initiative. As the project evolved, the role of the health plan became more central and diverged from the initial collaborative vision.
- L.A. Care as a Joint Powers Agency and Local Initiative must be locally responsive to the unique needs of L.A. County, and should invest in the alignment of County programs in order to meet its Medi-Cal obligations.

Importance of active/involved leadership and decision-making: Leadership time and availability for direct involvement in a collaborative project will likely always be limited, but the role of leaders is critical. Without formal sanctioning of the project and prioritization of the effort and resources required, collaborative activities like this will falter. Specific learning in this area include:

- Building relationships among the changing LAC Health Agency department leaders and with the new L.A. Care CEO will take time, especially given the multiple transformation initiatives in motion.
- HNJPC needs continued and expanded leadership endorsement and prioritization within their respective strategic and operational plans to achieve the shared vision and mission.

Role and authority of program managers: Given the limited availability of leadership, assigned program managers must receive clear direction, decision-making and real-time authority (as appropriate) to enable project success. Learning in this area includes:

- Participating agency leaders authorized pursuit of this project and assigned program managers to the Steering Committee to direct its development. With this additional assignment, program managers were challenged to continue all their day to day responsibilities while envisioning an effective and future-oriented delivery system.
- Program managers were excellent at visualizing an improved system and operationalizing systems change at the neighborhood level. However, they lacked the authority to commit agencies to the proposed change agenda.

Sequencing, timing and scale: The pace, size and order of planning activities for a developmental project like HNJPC in a County as large and diverse as Los Angeles is challenging, especially given a multi-agency collaborative structure. Related learning during HNJPC planning included:

- Gaining agreement to focus on a specific, shared population was an effective foundation around which to organize collaborative activities and begin to align activities.
- The second main activity was selection of locales or neighborhoods in which to develop the program, followed by analysis of specific, programmatic needs of the priority population. In hindsight, learning and planning would likely have been enriched if these steps were reversed. Understanding the unique system supports and program design for a vulnerable, difficult to serve population is critical early learning that should inform all subsequent steps.
- While a pilot, small scale project was considered, it became clear that fundamental delivery system design changes would be needed, such as a change in payment structure. This insight informed the need to make deeper changes in managed care systems (e.g. tracking of homeless status) and contracting strategies (e.g. payment structures that support 'no wrong door' access), even though initial implementation could still be in a relatively small scope to generate 'proof of concept.'
- The planning processes allowed for multiple levels of input—Steering Committee, Public Health Officers, County staff department from all three County departments, contracted mental health, primary care, substance abuse and regional homeless service and housing providers. Reviewing materials and data together fostered consensus, built relationships, validated the HNJPC vision, principles and recommendations.
- Aligning planning and development efforts with the State's 1115 "Medi-Cal 2020" Waiver and 2703 Health Homes program was very difficult, given the lack of detail on payment, eligible population, and services for each. Waiting for direction from these state-level pursuits would have delayed the project by at least 8 to 12 months. As such, planning had to proceed based on the general themes addressed in the waiver request and Health Homes program.

CHALLENGES & SUCCESSES OF PARTNER COLLABORATION

Alignment of priorities and investment: Collaborative development to support improved outcomes for a shared population requires explicit alignment of priorities and resources. Sufficient agreement must be gained regarding target population, regional focus, and core system changes. Given that each partner agency has its own mission, governance, core services, and funding streams, achieving alignment is difficult. Related learning included:

- Transformation planning and implementation are not at the same stages across the three L.A. County departments (Health, Mental Health and Public Health / Substance Abuse Prevention and Control) and L.A. Care. Each has a focus on homeless high utilizers but their implementation plans are not all coordinated into one master plan.
- Partners found it difficult to move from creating consensus around a shared vision to identifying and committing to concrete operational, resource, and policy changes that they could jointly or independently take. Operationalizing these commitments will be a key focus in the next year.
- Selecting only four communities of focus was challenging because there are so many L.A. communities experiencing high levels of homelessness, housing instability, and poverty.
- L.A. Care engaged in many one-to-one discussions with County departments and CCALAC staff in between Steering Committee meetings to assure that the HNJPC aligned with other efforts. These meetings have been essential to building relationships between County staff and the health plan.
- Project partners had difficulty coalescing to prioritize geographic areas for HNJPC selection. Consequently, not every region selected has high levels of the target population and a service delivery network prepared to engage in transformation activities.
- Community convenings and key informant (KI) interviewees challenged the selection of Pacoima and SELA as a match for the target population. Not selecting Skid Row, which has the highest concentration of homeless individuals, raised questions by DHS and others.
- Being responsive to those who work in the homeless field required revamping the target community maps in order to capture the homeless hotspots identified by the LAHSA homeless count and homeless agency experience.

Linkage/coordination with related programmatic initiatives: One of the greatest challenges and simultaneous biggest opportunities is linkage with partners' related efforts. Linkage represents the opportunity to avoid 'recreating the wheel' while still avoiding mission drift and acknowledging differences. There was considerable learning in this area during HNJPC's planning phase:

- Initially, HNJPC sought to build upon L.A. County's Health Neighborhood Initiative led by DMH, which was still in the early development stages. However, that project's general population focus (versus homeless individuals with MH and SUD needs) proved to be different enough that the two projects required separate strategies. The planning process, however, has provided value to County departments' staff and they have agreed to continue to convene and share cross system information.
- The largest County department, DHS, had already committed to systems-level transformation through the Housing for Health program, which provides intensive case management and housing placement as an intervention for the target population. DHS is actively moving vulnerable homeless clients who use County hospital services into service-enhanced housing and contracting with homeless service providers for client outreach, engagement and intensive case management.
- Although DHS operates multiple clinics, only two have specialized homeless services: the Star Clinic in Downtown LA and the Oasis Clinic operated by Charles Drew University on the MLK Campus.

[6] Detailed information regarding this program is available on the following website: https://dhs.lacounty.gov/wps/portal/dhs/housingforhealth

- DMH allocates one-half of its MHSA funding for the chronically mentally ill homeless and operates or contracts for a number of Full Service Partnerships to coordinate care for enrollees.
- Los Angeles County will be in Phase 2 of the Drug Medi-Cal Waiver amendment implementation and SAPC is nearing completion of implementation planning process, which included a series of local stakeholder meetings to discuss the implications for the target population.
- CCALAC represents several member clinic organizations that have specialized programs to serve individuals and/or families experiencing homelessness; these programs and specialized services are largely grant-funded and vary greatly among FQHC providers.
- L.A. Care has devoted considerable planning resources to this target population, but as yet, it does not have a specialized homeless services program.
- The planning process identified new resources in L.A. County (e.g. SB 82, new housing vouchers, expanding Housing for Health) that could be allocated to HNJPC; however, Steering Committee members had no authority to reallocate them.
- The L.A. County homeless services sector has worked to improve coordination of housing navigation and services for people experiencing homelessness, primarily through the implementation of the Homeless Family Solutions (HFSS) and Coordinated Entry System (CES). These regional systems (Service Planning Area-level) facilitate communication and matching of homeless families and individuals, respectively, with the most appropriate housing resources for their level of need. Implementation has created improved partnerships within the homeless services and housing sectors, but there are varied levels of health provider involvement.

REGIONAL VARIATION & LOCAL ENGAGEMENT STRATEGIES

Building local awareness and buy-in/engagement: From its outset, HNJPC sought to bring a local focus to planning and development activities, recognizing that programs must reflect local needs, resources, and challenges. Clearly this requires direct learning from and planning with local leaders and stakeholders. A great deal was learned in early planning activities about how to engage local leaders and lay the groundwork for ongoing collaboration:

- Engaging communities prior to department and health plan commitments for systems change is problematic. In order to engage community agencies over time, there needs to be a clear understanding of what health plan and public agencies' leaders intend to do differently and what new resources they will bring. Homeless service providers in particular described how their agencies are doing the maximum with current resources, and assuming more responsibility for complex homeless clients would require new sustained funding streams and resources.
- At the local level, community members sought to understand how multiple "health neighborhoods" initiatives fit together into one coherent plan that avoids duplicate efforts. Health agencies that serve complex populations are already saturated with systems transformation and "have planning fatigue". Despite this view, many contributed their expertise to this planning initiative.
- As a start-up planning process that lacked wide recognition, considerable time has been spent educating people about HNJPC. Sharing the adopted vision and guiding principles were a good starting point for engaging KI interviewees who were not necessarily known to L.A. Care or the consulting team.
- Community engagement and building relationships take time and sustained effort. In order to have community members respond to requests for meetings and interviews, L.A. Care developed materials for public education and assigned staff to be part of community engagement activities, albeit during too short of a time frame.

Defining/assessing local 'readiness' and level of need: Preparing to develop a specialized program in a given neighborhood required learning about both the needs of the population in that area and the existing capacity (and deficits) to meet those needs. Interviews, conference calls and planning sessions revealed highly varied levels of readiness and need, but were not sufficient in all selected areas to represent a comprehensive assessment. Key learning included:

- The selected four communities are not equally ready to implement systems transformation. Hollywood and the San Fernando Valley have strong, engaged homeless coalitions, years of collaborative efforts and personal relationships to build upon. By contrast, while Southeast Los Angeles and Watts/Willowbrook have some coalitions, they need more developmental activity to identify and engage key leaders (particularly all the ones that operate on the new Martin Luther King campus) and primary care clinics in a project like this.
- Given the size and complexity of Los Angeles County, the KI process had limitations. The selected neighborhoods are all large regions with multiple cities and varied health and homeless service infrastructure. The consulting team and County departments brought some expertise to identify key leaders as interviewees. The KI process was not a full environmental assessment and some individuals identified were unable to secure interviews within our time frame. Thus, this planning phase may not have fully identified and engaged the relevant local leaders and secured a full range of recommendations.

Local vs countywide management support: Efforts to incorporate location-specific needs and variables into the design of HNJPC's programs generated important learning. Impacts of this were revealed in several areas:

- While the County agencies have countywide and Service Planning Area-specific management infrastructure, L.A. Care does not. L.A. Care staff are not structured to work at the regional level to plan and implement systems transformation. Thus, it is premature to build specific regional plans without further regional engagement and commitment of staff to the local level developmental activities.
- In general, working at the regional planning level is problematic and premature without systems level commitments. Community agencies have little ability to implement service/referral changes without policy directives and departmental guidance issued to contractors and County staff. New resources need to be aligned by the health plan and County departments to enable community-based agencies to take on greater responsibility for case managing complex homeless clients.
- The regional plans need to reflect the input of KIs and local leaders rather than solely the Steering Committee members. For example, the proposal to focus on Pacoima was repeatedly challenged because homeless hot spots are located elsewhere in SPA 2 and a high percentage of the homeless population in Pacoima are undocumented and not eligible for Medi-Cal. Southeast Los Angeles' leaders report high levels of Latino families experiencing homelessness rather than the identified target population.
- Only some areas had region-specific collaborative planning tables with most or all relevant agencies represented, so consistently getting the right people in the room to engage in visioning and service delivery transformation is challenging.
- HNJPC partners can look to leadership from two selected regions, Hollywood and San Fernando Valley, SPA 2, as advisers to define and implement a specialty network for homeless individuals. Both of these regions have successful homeless coalitions and have implemented a variety of health-related projects together. For example, SPA 2 providers were awarded a CMS Innovations grant to improve transitions of homeless clients/patients from hospital to community services.
- The KI process identified that coalition building with hospitals for the purpose of improving transitions to community is a high priority.
- Connecting with first responders is important yet challenging because the Fire and Police Departments do not necessarily have staff they can assign to community level planning. However, they both play a key role in the crisis health system in identifying and transitioning homeless clients to inpatient care or criminal justice settings.

Recommended Future Steps

The option selected for implementation in the second year of the project is as follows:

> **Building on the Year 1 learning and collaborative infrastructure, Year 2 will focus on building a sustainable and scalable approach to coordinated services for homeless individuals. This phase will address delivery system design and network development to create integrated service networks across physical health, mental health, SUD services, and homeless services / housing supports. The service networks will address homeless individuals' needs and challenges in their preferred geographic locations. Project partners will use Medi-Cal funding streams to contract with providers for those services (e.g. a single organization with multiple integrated services or multiple organizations working together through aligned contractual requirements and incentives).**

A detailed set of recommended steps are described in a separate document prepared by IBHP for the HNJPC project: "Recommended Program Requirements and Implementation Plan." Some of the most important themes incorporated into the plan include:

- Take advantage of federal and state policy changes that affect systems transformation, including deployment of new resources (2703 Health Homes pilots and 1115 "Medi-Cal 2020" Waiver);
- Create an ongoing structure for the managed care plan leadership, County department directors, and clinic leaders to jointly plan systems transformation to support whole person care for complex-need individuals;
- Align shared initiatives to achieve whole person care;
- Build on existing managed care relationships with contracted hospitals to identify and engage the hospital staff who can commit the hospital to community collaborations;
- Determine milestones for systems redesign;
- Agree on quality and outcome measures;
- Develop and deploy policy guidance to department/managed care plan staff / contractors; and
- Revise / draft contracts to include quality and outcome measures.

Appendix A: Driver Diagram

Health Neighborhood Driver Diagram

Issue

Poor health outcomes for homeless individuals with co-occurring mental health and substance use disorders

Primary Drivers

Homeless Individuals:

- Aversion to health care and low expectations for health improvement
- Lack of appealing, welcoming and easily accessible health care services
- Lack of housing or poor housing (unstable, unaffordable, unsupportive)
- Lack of health literacy and/or consistent, health-promoting social supports
- Unhealthy environment (e.g. exposure to violence, lack of safety)
- Need to meet basic needs (e.g. food, shelter, transportation)
- Functional impairments and symptoms, particularly related to co-occurring mental health and substance use disorders
- Past or ongoing trauma
- Criminal justice involvement & reentry challenges
- Poor history of care; mistrusting of or unfamiliar with health & social service systems

Health Care Providers, Agencies, & Systems:

- Inadequate overall capacity and funding to meet degree and breadth of need (both "health care" and other services)
- Fragmented health care system that is episodic, difficult to access, and poorly coordinated
- Mismatch between services available through health care systems & patient/client preferences
- Funding is inflexible & siloed
- Funding largely tied to services, not improvement of health outcomes
- Services provider-driven & not patient-centered or culturally sensitive
- Stigma and discrimination
- Low expectations for possibility of health improvement by providers

Note: most drivers have both individual & provider/agency/system aspects.

Design Concepts

Improve Homeless Individuals' Access and Services

- Outreach and engage individuals experiencing homelessness
- Deliver care in flexible, appealing ways
- Coordinate care, services, & supports across the continuum of care
- Provide housing navigation in concert with other services

Create a Seamless System to Support Whole Person Care

- Create a shared L.A. County vision
- Define roles & responsibilities
- Align "health" funding to better meet the needs of individuals experiencing homelessness, to the extent possible
- Redesign safety net infrastructure to support whole person care for individuals experiencing homelessness
- Track progress toward improvement of outcomes for individuals experiencing homelessness

Appendix B: Acknowledgments

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