Alameda County Whole Person Care Pilot Population

The WPCP **eligible population** is comprised of those who are **Medi-Cal eligible** and who fall into **at least one of the following target populations**. We anticipate significant overlap between the target populations.

Target Population #1: Homeless – Literally and at-risk-of

	HUD Definition	HRSA Definition (Broader)
Category 1	Individuals and families who lack a fixed, regular, and adequate nighttime residence, including a place not meant for human habitation	They are living on the streets; in an abandoned building or vehicle;
	Living in a shelter (Emergency shelter, hotel/motel paid by government or charitable organization)	Their primary nighttime residence is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations. They are staying in a mission.
	Exiting an institution (where they resided for 90 days or less AND were residing in emergency shelter or place not meant for human habitation immediately before entering institution)	They were previously homeless, are to be released from a prison or a hospital, and do not have a stable housing situation to which they can return
Category 2	Individuals/families who will lose their primary nighttime residence within 14 days, and who: - Have no subsequent residence identified AND - Lack the resources or support networks needed to obtain other permanent housing	
Category 3	Unaccompanied youth (under 25 years of age) or families with children/youth who: - Have not had lease, ownership interest, or occupancy agreement in permanent housing at any time during last 60 days - Have experienced two or more moves during last 60 days - Can be expected to continue in such status for an extended period of time because of: chronic disabilities, OR chronic physical health or mental health conditions, OR substance addiction, OR histories of domestic violence or childhood abuse (including neglect) OR presence of a child or youth with a disability, OR two or more barriers to employment	
Category 4	Individuals/families fleeing or attempting to flee domestic violence, dating violence, violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member and: - Has no identified residence, resources or support networks - Lacks the resources and support networks needed to obtain other permanent housing	

HUD Definition		HRSA Definition
		They are a resident in transitional housing
		They are staying in a single room occupancy facility,
		They are "doubled up," unable to maintain their housing situation and forced to stay with a series of friends and/or extended family members.
		They are staying in **any other unstable or non-permanent situation**.

DECISION: Which definition to use?

- *HUD Definition is narrower and more carefully accounted for in the HMIS database, providing an easier denominator for monitor outcomes*
  - *~10,000 people are in the HMIS data system for 12 months meeting narrower HUD definition*
  - *This could be used as the denominator for this target population.*
- *HRSA definition is broader, making it easier for clients to qualify for the WPCP target population but harder to determine the denominator up front*
  - ~10,000 people are served annually through HCSA's Health Care for the Homeless Program which uses the broader HRSA definition, but we assume many more qualify
  - Housing issues were named as a primary issue throughout key informant interviews. Does the HUD definition cover this need, or is the flexibility of the HRSA definition needed to capture those whose health outcomes are influences by housing instability?

Target Population #2: Serious Persistent Mental Illness (SPMI) – 8,509 Alliance Medi-Cal Clients

a. Being on a service team (called Level 1: ~3,300 clients) or FSP (~780 clients) and/or
   i. Already with significant care coordination services including housing navigation
b. 3 or more episodes with an SPMI DX with the last service occurring in the last 3 years and/or
c. 10 or more SPMI DX episodes ever (data goes back as far as 1991)

Target Population #3: High Users of Multiple Systems – 6,509 Alliance Medi-Cal Clients

a. Touching any two of the following systems in a 12 month period
   i. Medical crisis/high acuity utilization in 2015
      1. 3 or more ED visits OR
      2. Inpatient stay (other than for pregnant women giving birth) OR
      3. Medical Sub-acute
   ii. Mental Health high acuity utilization in 2015/high need
      1. 2 or more PES/5150 OR
      2. Psych inpatient admission OR
      3. IMD
      4. SPMI as defined above (on a service team/FSP or multiple episodes with SPMI diagnoses)
   iii. Substance Abuse Treatment Services: at least one SUD service in 2015
   iv. Incarceration
      1. Discharge from Santa Rita in 2014
      2. AB109 Clients

3. Others with known Person File Number (PFN) in sheriff system

Target Population #4: High Users of Emergency Services (even within one system) in a 12 month period

a. 3 or more ED visits (13,713 Alliance Medi-Cal clients; 12,674 had no visit to PES)
b. 2 or more PES visits (1,045 Alliance Medi-Cal clients; 189 had no ED visit)

Overall, the Health Homes Program and Alameda Health System's Complex Case Management are intended to care for those who are very medically sick, with or without behavioral health issues. This group may often have multiple hospitalizations due to their conditions. The Whole Person Care Pilot on the other hand is intended to meet the needs of those who have significant unmet social needs, housing instability, and substance use issues that often lead to inappropriate seeking of emergency services across siloed systems with no cohesive consistent care coordination to assist the client in getting the care they need. There is certainly overlap, and the Whole Person Care Pilot will determine when an individual already has a care coordinator, if there are services that the client is already eligible for through other programs, and if there are gaps in services that Whole Person Care might cover.