

CROSS SYSTEM INTEGRATION AS A MEANS FOR ADDRESSING SOCIAL DETERMINANTS OF HEALTH

**4TH ANNUAL INNOVATIONS SUMMIT
ON INTEGRATED CARE**

October 7th, 2016

WELCOME

Karen Larsen, LMFT

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Yolo County Health & Human Services Agency (HHS) Director**

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HHS Adult & Aging Branch Director

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HHS Adult & Aging Clinical Manager

YOLO COUNTY

Population just over 200,000

Median Income-\$57,260

Persons below poverty level 18.7%

Culturally Diverse

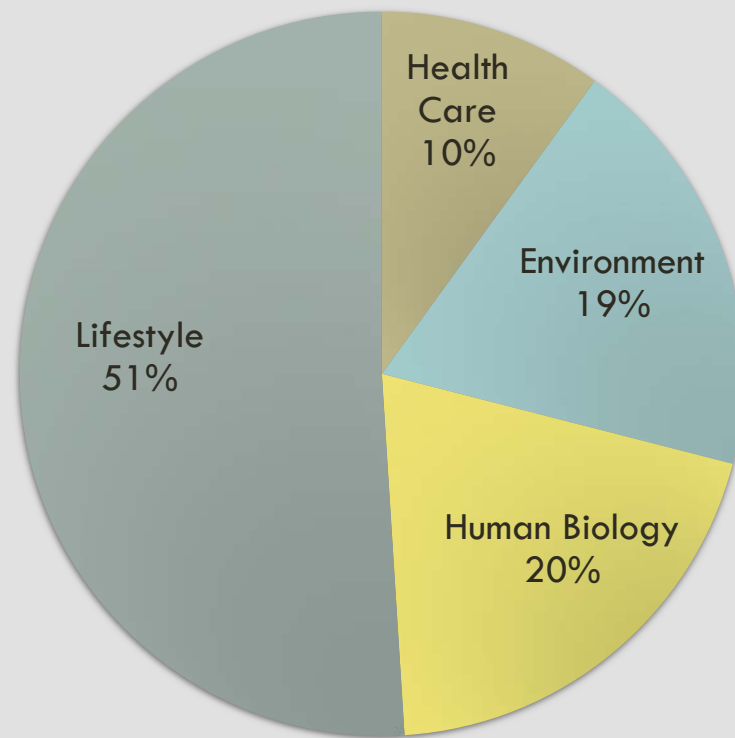
Geographically Diverse



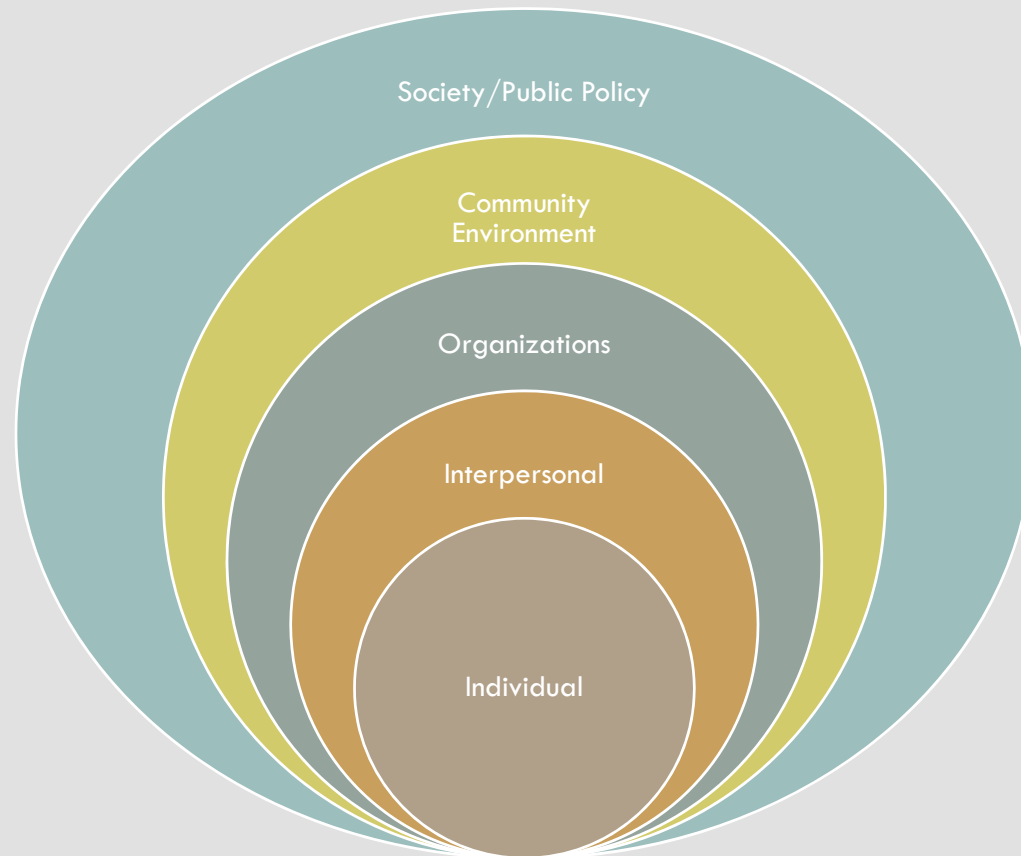
SOCIAL DETERMINANTS OF HEALTH



HEALTH DETERMINANTS



IT'S ALL CONNECTED



CROSS SYSTEM INTEGRATION: FORENSIC PROGRAMS

Community Intervention Program/Mobile Crisis

Mental Health Court

Assisted Outpatient Treatment

Crisis Intervention Training

1368 Misdemeanant Competency Restoration

Stepping Up Initiative – County Strategic Goal: Safe Communities; prevention through services

Community Corrections Partnership

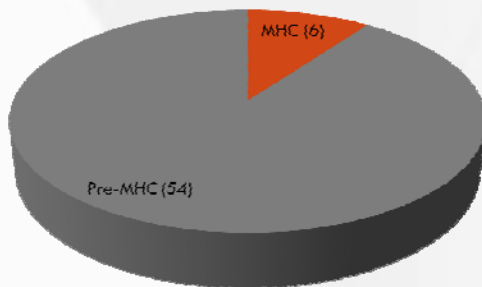
- Proposition 47 Pilot
- Multi-disciplinary Review Team
- 1170's Split-sentence Planning
- Use of Intergovernmental Transfer (IGT) funds—House for Probationers
- Pending Board of State and Community Corrections (BSCC) Proposal

OUR PARTNERS

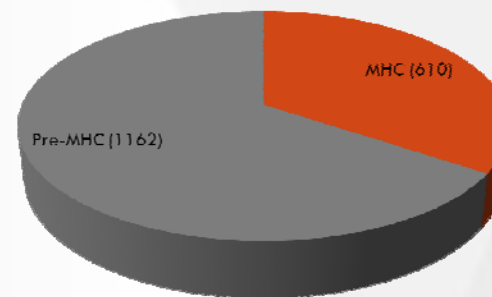


MENTAL HEALTH COURT OUTCOMES

of Arrests: 88.8% Reduction

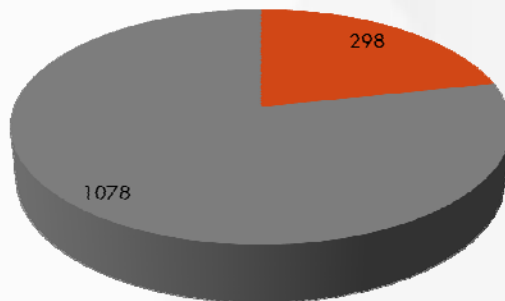


Days Incarcerated: 47.5% Reduction



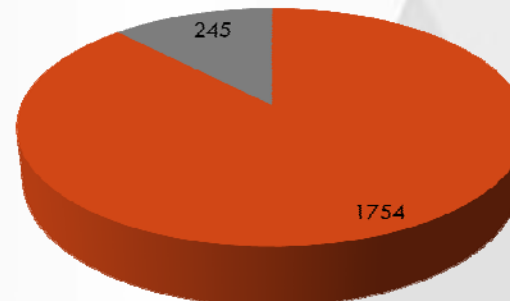
Days Incarcerated (Minus Client X): 72% Reduction

■ MHC (-312) ■ Pre-MHC (-84)



Treatment Engagement: # of Treatment Appointments Attended – 700% Increase

■ MHC ■ Pre-MHC



CROSS SYSTEM INTEGRATION: HOMELESS SERVICES

Bridge to Housing: 2014/15 Pilot Project

Bridge to Health & Housing: Partnership Health Plan – addresses medical vulnerability

Extended Hope: Substance Abuse & Mental Health Service Administration (SAMHSA) Cooperative Agreements to Benefit Homeless Individuals (CABHI) – addresses substance use disorders

Homeless Services Continuum:

- Homeless Poverty and Action Coalition (HPAC)
- Coordinated Entry: Homeless Management Information System (HMIS)
- System-wide Assessment Tool: Vulnerability Index—Service Prioritization and Data Assessment Tool (VI-SPDAT)

City-specific Initiatives: 50/50 County/city cost sharing

Embedded County Staff: Outreach Teams; Homeless Neighborhood Court

OUTCOMES: RESULTS BASED ACCOUNTABILITY

Bridge to Housing Pilot

1. What Did We Do?

- Participants Served: 65 of 71 stable residents of the North Levee Encampment entered the program in November 2014.
- Temporary Bed Nights Provided: The temporary housing component of the program operated for 109 days, and provided a total of 6,204 nights of temporary housing at the motel.

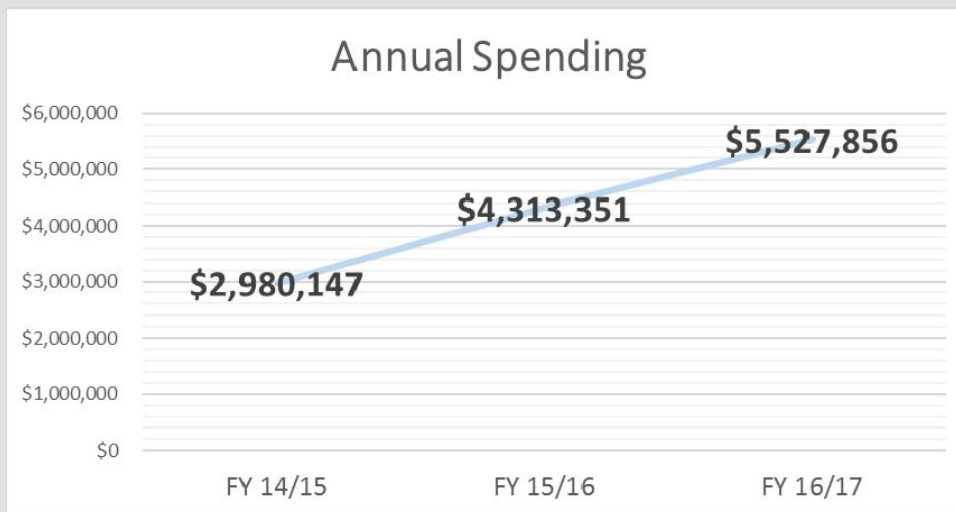
2. How Well Did We Do It?

- Retention Rate in Program: 82% (53 participants) remained engaged at the end of the program.
- Engagement Rate After Program: 79% (42 of the 53 participants who completed the program) remained engaged in services with case managers 12 months after exiting the program.

3. Is anyone better off?

- 72% (38 of the 53 participants who completed the program) secured permanent housing.
- 32 remained housed at 15 months.

GROWING THE RESOURCES



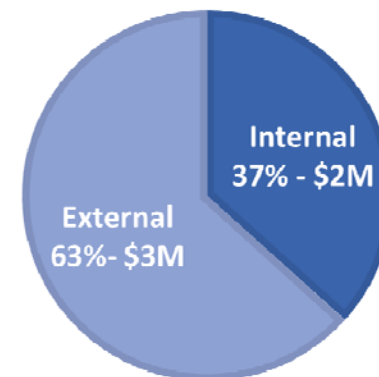
Next Steps:

- Comprehensive list of funding opportunities
- Apply for new grants

Accomplishments:

- Received \$0.5M grant for medically vulnerable
- Received \$2.4M grant for people with co-occurring disorders

INTERNAL VS. EXTERNAL SPENDING



CROSS SYSTEM INTEGRATION: OLDER ADULT SERVICES

County Older Adult Mental Health Care Team

- Clinicians, Case Managers, Geriatric Psychiatry

Care Coordination Learning Collaboration (CCLC): PDSA Cycles

Yolo Adult Day Health: County-wide effort to expand/re-locate; embedded Mental Health Clinician groups

Yolo Healthy Aging Alliance: Board of Directors

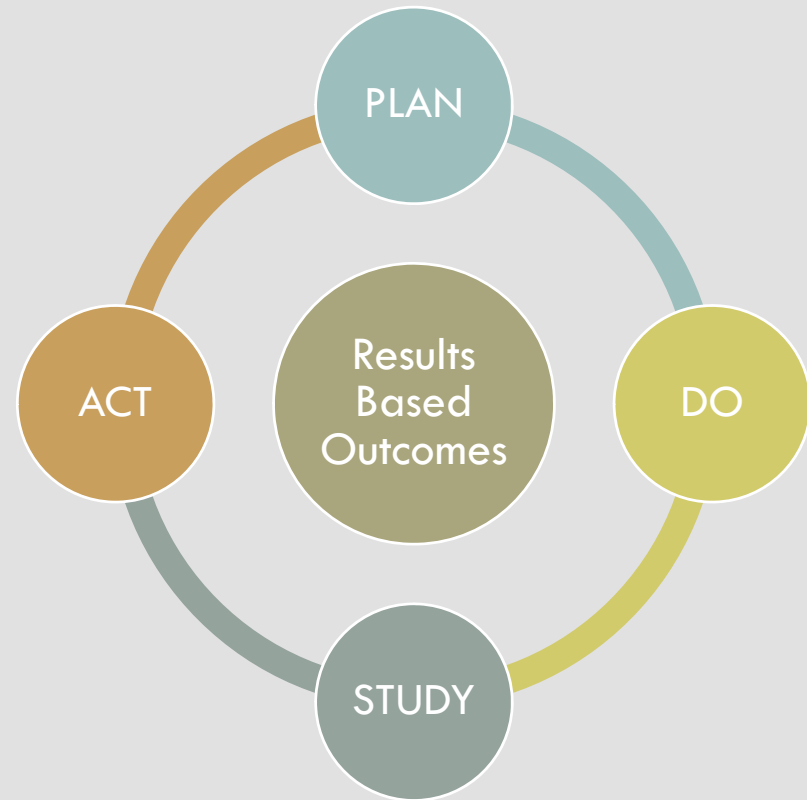
- Collaboration, Advocacy, Education

Yolo County Commission on Aging

CROSS SYSTEM INTEGRATION: CCLC

GOALS:

1. Identify the number of older adult clients of Yolo County HHSA who have SMI and at least one chronic health condition, through a screening process.
2. Improve self-management of chronic health conditions.
3. Improve health outcomes for the target population.
4. Develop and implement medication reconciliation processes for older adults.
5. Improve coordination of care with primary care providers.



- AIM: Identify older adult individuals with co-morbid chronic health conditions and serious mental illness, who are receiving services by the older adult care team, to begin the cross system coordination, integration and collaboration with primary care and behavioral health providers in the community, and improve health outcomes.

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