A Slow-Moving Catastrophe: Finding The Ill Homeless A Place To Heal

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ISSUE

How can San Mateo County improve the coordination of services for medically ill and recovering homeless residents while managing County resources most effectively?

SUMMARY

"*EVERYONE IS WORKING ON HOMELESSNESS"*[1]

On February 21, 2020, California Governor Gavin Newsom gave the annual State of the State speech, with a major focus on homelessness and how his administration would respond to the growing crisis. With a significant "rainy day fund" or reserve budget, the Governor called homelessness "the issue that defines our times" and pledged $750 million dollars to address the needs of California's approximately 151,000 homeless including expanding Medicaid health services.

Then came COVID-19.

The Governor is planning heavy cuts to close an estimated $54 billion budget deficit brought on by the expensive consequences of treating the Covid-19 virus, loss of tax revenues due to the economic downturn, as well as increased payment of unemployment benefits.[2]

Now more than ever, San Mateo County needs a lean, coordinated, and comprehensive plan for efficiently housing the homeless and treating those homeless who are ill.

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[1] Official of Behavioral and Recovery Services: interview by the Grand Jury of a Mental Health Manager.
2 Western Center on Law and Poverty: Analysis of Governor's Newsom's Proposed State Budget 2020-2021 https://wclp.org/wp-content/uploads/2020/01/20-21-Budget-Analysis.pdf.

As of 2019, San Mateo County had an estimated homeless population of 1,500 individuals[3] spending approximately $54 million dollars annually on services for them – equating to about $36,000 per person.[4] While the struggle to help *all* homeless people is a significant concern, the issue of how to help the *ill* homeless presents an even greater challenge, one that involves multiple County departments, agencies and programs.[5] The ill homeless are particularly vulnerable because their living conditions are not consistent with a healthy lifestyle, let alone recovery from serious injury or medical conditions.

During the Grand Jury's investigation of the ill homeless in the County, it became apparent that, indeed, "everyone is working on homelessness." The Grand Jury also found that the lack of an overarching coordinating body that includes stakeholders from appropriate County agencies, including housing, behavioral, and physical health, has led to a multiplicity of approaches, which can sometimes impede the County's ability to efficiently address the needs of homeless individuals, especially those with medical issues. Other important issues identified by the Grand Jury include:

- Costs to the County for supporting the homeless and the ill sub-set are difficult to determine; yet, expense estimates are very high given the actual number of homeless residents.
- A shortage of homeless shelters for single adults that offer the necessary medical support for ill and recovering individuals.
- Pilot projects on medical respite or recuperative care, which provide greater medical care and longer-term housing than the usual homeless shelters, are showing promising results but currently meet a fraction of the need.
- Integrating physical and behavioral health data with housing and agency data from other services needed for County agencies to treat the medical and psychological conditions of the homeless is in progress but far from complete.
- A lack of affordable, permanent housing remains an obstacle to ending the cycle of homelessness as many homeless are elderly and have significant co-occurring health issues that complicate their abilities to maintain shelter.

The Grand Jury recommends that the San Mateo County Board of Supervisors:

- Direct the County Manager's Office to work with the appropriate County departments to develop an integrated viable medical recuperative care plan for the ill homeless that involves all key stakeholders and takes into account the new programs and practices initiated in pilot projects.
- Require the County Manager's Office to produce an annual report, to be presented to the Board at a public meeting, outlining the expenditures from all County departments and

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[3] San Mateo County: "2019 One Day Homeless Count and Survey," prepared by the SMC Health Services Agency, Center on Homelessness. The total is 1% of the total state homeless population. https://hsa.smcgov.org/sites/hsa.smcgov.org/files/2019%20One%20Day%20Homeless%20Count%20report.pdf.

[4] Official from SMC Budget, Policy, and Performance unit: email message to the Grand Jury.

[5] Agencies including, law enforcement, Human Services, Housing, and the County's Budget, Policy, and Performance unit, local hospitals, clinics, together with the Healthcare for the Homeless and Farmworker Program, The Hospital Consortium of San Mateo County, and the Health Plan of San Mateo.

funding sources that relate to the County's care for the homeless and the ill-homeless subset specifically.

- Direct the County Manager's Office to work with the appropriate County departments to explore options for purchasing and managing supportive housing for the fragile and ill homeless given the many comorbid conditions of homeless people and their lack of preparation for the responsibilities of living on their own.
- Direct the County Manager's Office to work with the appropriate County departments to address the needs of the ill and elderly homeless in the rebuilding of the Maple Street Shelter.

GLOSSARY

- San Mateo County Behavioral Health and Recovery Services (BHRS): A division of the County's Health System which is responsible for providing mental health and substance use care for residents of San Mateo County who are on Medi-Cal or are uninsured.

- Center on Homelessness: Part of the County's Human Services Agency (HSA) and the coordinating entity for the County's *Continuum of Care* program to distribute state and federal funding for low income and homeless residents. HSA contracts with eight Core Service agencies to provide comprehensive services for these populations through health clinics, shelters, and resource centers.

- Healthcare for the Homeless and Farmworker Health Program (HCH/FH): The program that is funded by the U.S. Department of Health Resources and Services Administration (HRSA) to provider health care and support services for the homeless and County farmworker populations.

- Health Plan of San Mateo (HPSM): A Medi-Cal managed care plan that provides insurance coverage to approximately 100,000 San Mateo County underserved residents including the homeless.

- Human Services Agency (HSA): The County department responsible for helping vulnerable County populations with emergency safety net services (e.g., food and housing, financial assistance, health insurance, job training, and access to homeless shelters).

- Hospital Consortium of San Mateo County: A nonprofit organization of County hospitals (comprising Redwood City Kaiser Permanente Hospital, Mills-Peninsula Medical Center, San Mateo Medical Center, Stanford Hospital, and Seton Medical Center) which enables member hospitals to work together to solve common problems and accomplish mutual goals.

- County Public Health, Policy and Planning Division (PH/PPD): A division within the San Mateo County Health System responsible for preventing the spread of communicable diseases, providing public health laboratory testing, and delivering targeted health care services, including many homeless health services.

- San Mateo Medical Center (SMMC): The County public hospital providing primary care, specialty care, and emergency services for low income and uninsured individuals (including the homeless) and their families.

- Whole Person Care Pilot (WPC): A five-year $82 million pilot project funded by Medicaid, state, and County dollars. WPC involves 16 County agencies and community non-profit partners and was created to provide innovative health and housing services for high risk individuals (including the homeless) who are high users of expensive medical services, especially emergency departments. The goal of the project is to better coordinate health services while reducing costs.

BACKGROUND

In 2016, the County's *Center on Homelessness* released a report called *Ending Homelessness in San Mateo County* which set forth the goal of ending homelessness in the County by 2020.[6] However according to the most recent One-Day Biennial Count of the County's homeless completed in 2019, this goal is far from being accomplished.[7] The 2019 homeless census revealed that 901 individuals were "unsheltered" (e.g., living on streets, in cars, in recreational vehicles, or tents/encampments), and 611 were "sheltered," (e.g., living in emergency shelters or transitional housing programs). The total number of homeless was 1,512 and is an increase of 21% over the prior homeless census completed in 2017, suggesting a persistent and growing County problem.

While the struggle to help all homeless is a significant concern, the issue of how to help the *ill homeless* has presented an even greater challenge, involving multiple County departments, agencies and programs. The ill homeless need medical assistance in addition to help with housing and finances. They are particularly vulnerable because their living conditions are not consistent with a healthy lifestyle, let alone recovery from serious injury or medical conditions.

Homeless individuals who have been discharged from the hospital but are not fully recovered face many difficulties since they require safe and clean accommodations as well as medical support to fully recuperate. Returning to homelessness is not a viable option, but where can they go?

Hospitals across the State have struggled with this issue for years and Californians have heard horror stories about such patients being dumped back onto the street still wearing hospital gowns.[8] The State took action (effective January 1, 2019) by passing SB1152, which mandated

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[6] San Mateo County Human Services Agency Report: *2016 Ending Homelessness in San Mateo. County*.https://hsa.smcgov.org/sites/hsa.smcgov.org/files/HomelessReport_Final.pdf.

[7] Human Services Agency: *2019 One Day Homeless Count and Survey* https://hsa.smcgov.org/2019-one-day-homeless-count.

[8] Cynthia Hubert, "Homeless Patients Were Left On The Streets By Hospitals. This Law Could End 'Dumping," *The Sacramento Bee*, October 9, 2018.

certain post discharge conditions to protect the ill homeless.[9] This law requires that hospitals assist homeless patients in identifying post hospitalization destinations such as a homeless shelter; provide referrals to appropriate services; and document the locations where the patients were discharged.[10]

In addition to patients being discharged from hospitals with follow-up medical needs, there are other categories of ill homeless who need medical care. These include individuals who have ongoing medical needs such as chemotherapy or patients who require wound care and/or pain management following outpatient procedures. Finally, there are ill homeless who need regular assistance with medication compliance or help with managing chronic medical issues such as blood sugar monitoring and insulin treatment for diabetes.

The Grand Jury's investigation focused on identifying options to improve the health outcomes of the ill homeless AND how the County could contain costs (a major concern of the discharging hospitals and County agencies). The Grand Jury considered the following:

1. How to *minimize serious illness* among the homeless by linking them to "outreach" or "in the field" (community) services which can provide medical care before hospitalization becomes necessary;

2. How to *find the appropriate level of temporary care* of homeless *to meet their medical* needs at the time of discharge;

3. How to *connect these individuals to County housing services consistent with their level of function* and prevent them from recycling back into homelessness.

These three concerns are examined in the sections that follow. The final section considers the impact of a five-year federal (Medicare), state and County funded $82 million grant called the *Whole Person Care Pilot* (WPC).

The WPC project involves 16 County agencies and community partners, offers a significant financial stimulus to re-structure Medi-Cal based health services for low income and homeless residents[11] as well as increase coordination among agency services.[12] This funding is in addition to the estimated budget of $54 million annually devoted to homeless services by San Mateo County.[13]

The figure below outlines the major programs and agencies which are referenced in this report. Most are involved in the WPC.

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[9] California Senate Bill No.1152: *Discharge Planning Law*, effective January 1, 2019.

[10] *Ibid*.

[11] This information is also presented in table format in Appendix C.

[12] Whole Person Care Pilot Grant (WPC). According the project proposal, 5000 "unique beneficiaries over the entire pilot" were expected to benefit from the programs."

[13] Officials from the County's Department of Housing and Budget, Policy, and Performance unit: email message to the Grand Jury.

ILL HOMELESS

San Mateo County Agencies and Initiatives

Agencies	Initiatives
Housing	
Department of Housing	
Center on Homelessness	Homeless Engagement Assessment and Linkage (HEAL)
Human Services Agency	Shelters and homeless outreach
Medical	
County Health System	Whole Person Care Pilot (WPC) Coordinating Group
San Mateo Medical Center	Diversion Coordinators & Peer Navigators
Public Health Policy & Planning	Mobile Health Clinic/Van & Street Medicine Team
Health Plan of San Mateo	Pilot Projects: Baden Street Shelter and Post-Acute Care Program (PACP)
Healthcare for Homeless and Farmworker Program	Mobile Health Clinic/Van & Street Medicine Team
Behavioral/Mental Health	
Behavioral Health and Recovery Services (BHRS)	Homeless Outreach Team (HOT) Board & Care placement for psychiatric homeless
Law Enforcement	
County Sheriff Office	Psychiatric Emergency Response Team (PERT)
City Police Departments	Homeless Outreach Coordinators
Whole Person Care Pilot	
16 County and Community Agencies	Community Health Outreach Workers (CHOW) Bridges to Wellness Team (BTW) BTW Resiliency Specialists Care Navigators/Mentors in Discharge - Peer Mentors Psychiatric Emergency Response Team (PERT)

Community Agencies

Substance Use Treatment
Star VIsta
Voices of Recovery
Heart and Soul
Horizon Services
Health Right 360

Housing
LifeMoves:
Homeless Outreach Team (HOT)
Maple Street Shelter
Brilliant Corners:
Housing and Supportive Services

Health Policy Organizations
The Hospital Consortium:
Recuperative Care Policies/Plans

DISCUSSION

The Discussion is organized into four sections, which track the potential journey of a homeless County resident who becomes ill.

Section 1: Reaching out to the Ill Homeless

Homeless persons differ widely with regard to their health status (including both mental and physical impairment). Poor health status is further distinguished by whether or not the disorder is acute and curable or not. Supplying early medical treatment to this population promotes health and can minimize costly future hospitalizations. Because many homeless are poorly connected with preventive or primary care services, the County supports a variety of health outreach efforts that treat the homeless where they live: under bridges, hidden in the County's large undeveloped green spaces or in plain sight on the streets.[14]

The County's Center on Homelessness funds *Homeless Outreach Teams* or *HOT* under a contract with LifeMoves, a nonprofit community organization. HOT consists of small groups of trained individuals who go into homeless camps to provide linkages to health (and other) services. Depending on the situation, they may take an individual directly to a hospital[15] or to a nearby clinic specifically set up for low income and homeless people with non-life threatening concerns,[16] or to a shelter where they can recover in sanitary and safe conditions.[17] The HOT team may also connect ill homeless with *Street and Field Medicine,* a program that sends out "back pack" medical personnel to treat those with mild ambulatory health concerns.

Another option for non-urgent care is the County's *Mobile Health Clinic Van.* The van moves throughout the County to pre-designated sites on a weekly basis including several homeless shelters.[18] Services provided include illness and injury treatment, primary and preventive care, as well as referrals for mental health services and needle exchange.

The fact that so many homeless have comorbid or co-occurring mental health issues has stimulated the County to add psychiatric expertise to outreach teams. For example, an 18- month pilot project funded by the State has created a specialty outreach team called *Homeless Engagement Assessment and Linkage,* (*HEAL)* to provide one-on-one mental health therapy for homeless in the field.[19] This team then partners with HOT to encourage the homeless to move into shelters and to obtain other appropriate services.

Law enforcement officers are a vital County resource who provide significant outreach assistance to the homeless. A Redwood City police officer interviewed by the Grand Jury noted that about 90% of day shift work pertains to issues of the homeless and that 20% of such calls involve medical or drug related problems.[20] Several cities with high homeless populations (i.e.,

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[14] Supra 6. SMC cities with the most to the least number of unsheltered homeless: Redwood City, Pacifica & coast side unincorporated area, East Palo Alto, and the City of San Mateo.

[15] Usually the San Mateo Medical Center (SMMC), the County's safety net hospital for low-income County residents.

[16] For example, Fair Oaks Clinic in San Mateo or Ravenswood Clinic in East Palo Alto.

[17] For example, Maple Street Homeless Shelter.

[18] Official from HSA: interview with the Grand Jury.

[19] Official from HSA: interview with the Grand Jury.

[20] Officials from law enforcement: interview with the Grand Jury.

Redwood City and City of San Mateo) have assigned specially trained officers to full- or part-time homeless duties as *Homeless Outreach Coordinators.*[21]

Among their responsibilities are regular visits to homeless encampments and coordination with health and housing services. Such visits increase trust so that officers can be viewed as helpers rather than just enforcers. Police who have had training in working with the homeless provide an additional layer of safety for the homeless and the outreach personnel who work with them. With their knowledge of the medical and mental health resources available, difficult homeless individuals can be quickly removed from situations where they may be a harm to themselves or others. Many of these officers have been trained in mental health issues by the Behavioral Health and Recovery Service (BHRS) *Field Crisis Team*. Such training is offered twice a year.[22]

The common goals of all County outreach programs are to respect the individual choices of homeless individuals and at the same time, ameliorate illness and suffering. While labor intensive, expensive and sometimes heartbreaking to the care providers involved, the alternative of hospitalization comes with an exponential increase in medical costs, compounded by the risks from delayed health care.

Section 2: When Hospitalization is Required

The County's primary hospital that serves impoverished and homeless people is San Mateo Medical Center (SMMC). Medi-Cal, the state version of Medicaid, insures low income adults, families with children, seniors, persons with disabilities, pregnant women, and children in foster care up to age 26. Forty percent of SMMC's patients are insured by Medi-Cal making this hospital the largest provider in the County for this population. In San Mateo County, Medi-Cal benefits are administered by the Health Plan of San Mateo (HPSM). The Plan was founded in 1987 by the San Mateo Health Commission as a non-profit healthcare plan to offer insurance and health care to approximately 100,000 of SMC's low-income residents including the homeless.

In calendar year 2019 the SMMC provided treatment to 886 hospitalized individuals identified as homeless.[23] Criteria for homelessness included patient self-reporting of living on the street, in transitional housing (i.e., moving from the street into supported housing), in a homeless shelter, "doubling up" or sharing space with others temporarily, or "Other." The "Other" category included living in single room occupancy dwellings (SROs), motels or day-to-day paid housing.[24]

This homeless patient group made a total of 2,217 visits to SMMC. What stands out is the number of repeat visits: 18 individuals (approximately two percent) had 436 encounters or 20%

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21 Ibid.

22 Besides conducting training, the Field Crisis Team involves 50-60 people from various County agencies and departments as well as Community Based Organizations (e.g., Life Moves, the National Association for Mental Health, and CAMINAR) in addition to law enforcement who meet monthly to discuss how to engage specific problematic individuals into treatment and avoid incarceration. Going beyond behavioral health issues, the group also welcomes representatives of the County Ombudsmen and the District Attorney's Offices.

23 Official from SMMC: interview by the Grand Jury.

24 Ibid.

of the total visits for 2019. Discussions with SMMC medical personnel paint a picture of complex patients who, for various reasons, decline medical treatment until their situation becomes very serious.[25] Other patients in this group rotate through the hospital, often substituting *Emergency Department (ED)* visits for routine medical care.

The financial cost consequences to SMMC and HPSM are significant and have incentivized them to support outreach health options (such as the HOT and HEAL teams described above) to try and address homeless medical issues before hospitalization is required. SMMC and HPSM have also expanded care within the hospital that goes beyond addressing physical health.

Termed "wrap around" services, SMMC employs social workers to connect homeless patients to housing (including re-establishing relationships with family and former house mates) as well as to appropriate social programs in order to increase the likelihood of positive post-discharge outcomes. Referrals also include outpatient treatment for Substance Use Disorders (SUDs), mental health, as well as connection to primary care clinics for ongoing medical monitoring and preventive care.[26]

The County has also begun to invest in "diversion" services, designed to "divert" the homeless from returning to the street after hospitalization at SMMC. A pilot project funded by the Center on Homeless involves two *Diversion Coordinators* hired to assist the recovering homeless in connecting to relatives or friends, paying back rent or obtaining help with utilities, as well as information about affordable housing options. The coordinators may also place a recovering homeless client at the County's Samaritan House Shelter if no alternative can be found.[27]

Section 3: California Law SB 1152 and the Ill Homeless

The homeless face significant difficulties upon hospital discharge in terms of finding safe and clean accommodation in which to fully recuperate. The urgency of the issue prompted the State to pass SB 1152 (effective January 1, 2019), which mandated certain post-discharge conditions to protect the homeless. All hospitals are required to comply with this new law which requires a written statement of "homeless discharge planning policy and practice."[28]

Specific requirements of the law include connecting patients to community resources (e.g., shelter, treatment, social programs), provision of information about housing with post-hospitalization medical services and supplying necessary medical information about the patient to the follow-up facility. Other conditions include providing appropriate clothing, a meal, a prescription or medicine if available, and screenings for infectious diseases and vaccinations. Importantly, all communication with the patients must be conducted in a culturally appropriate manner and language.

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[25] Ibid.

[26] Official from SMMC: interview with the Grand Jury.

[27] Official from HSA: interview with the Grand Jury. Samaritan House is one of three HSA Core Agency Shelters.

[28] CA SB 1152 law.

SB 1152 also mandates that a connection be made with the homeless patient's health care plan (or if none, that assistance in enrolling in any eligible health insurance option be provided) as well as connecting the individual to a primary care provider or other appropriate medical personnel. Information is supplied about the County's *Coordinated Entry System (CES*) evaluation, which is necessary before County-supported resources can be obtained, including shelter housing.

Finally, the law requires that hospitals maintain a "Discharge Log" which codes the identification of the patient, where the person was discharged, and assurances that all requirements of the discharge plan were fulfilled. Hospital Discharge Logs from all County hospitals will be a source of important data in understanding the needs and issues of the ill homeless population over time.

In sum, while SB 1152 goes far in identifying and attempting to address issues of importance for facilitating effective post-hospitalization care of homeless patients, within the relatively short time of its implementation, the lack of sufficient number and type of housing options (i.e., capable of supporting recovery) has become critical. The section below examines both traditional and new approaches to caring for recovering ill homeless.

Section 4: Post-Hospitalization Options for the Ill Homeless

Until recently, patients in need of a supportive and safe recovery environment could reside at a *Residential Care Facility for the Elderly.* Because not all of their patients are elderly, these facilities are more commonly known as "Board and Care" homes. Usually small residences that house six or fewer people, and provide shelter, meals, socialization and assistance with some daily living activities (including minor medical care) for their residents. Historically, many have become permanent homes for the elderly with few resources, as well as those suffering from mild mental illnesses and those with some degree of developmental disability who have few independent living options.[29]

In the San Francisco Bay Area, many Board and Care homes have closed because of high minimum salaries for workers, the cost of maintaining property, and the opportunity to sell the properties at a large profit for redevelopment. Even the remaining homes are no longer financially accessible, with costs to residents averaging over $3,500 monthly, much more than low-income individuals relying on Supplemental Security Income (SSI), disability and/or Medi-Cal benefits can afford.[30]

Due to the lack of inexpensive rental housing such as Board and Care residences as well as the requirements mandated by California Law SB 1152, *County hospitals have coped by keeping homeless patients hospitalized when no other housing was possible.*[31]

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[29] Official from BHRS: interview with the Grand Jury.

[30] Ibid.

[31] Officials from Santa Clara Valley Medical Center and SMMC: interviews with the Grand Jury.

Data provided by the SMMC for calendar year 2019, for example, indicated that 37 homeless individuals were "Admitted to SMMC" at discharge, in other words, kept in the hospital because no appropriate post-hospitalization bed or destination was available. While this is the legal and compassionate choice, there are drawbacks including cost and limiting the availability of beds which could be used by acutely ill or injured patients.[32]

As an alternative to continuing to hospitalize homeless patients who are ready for discharge, local hospitals[33] and BHRS have begun a practice of reserving or "buying beds" at County homeless shelters. While the County has 12 shelters, some are restricted to special populations, such as domestic violence victims (*CORA),* those with serious mental illness (*Spring Street*), young adults (*StarVista-Day Break*), and families (five sites including *Hope and Home*).

Shelters designed for single homeless persons include: Maple Street (run by LifeMoves),[34] Samaritan House, Safe Harbor and Project WeHOPE, run by the County Human Services Department (HSA). Only three County shelters (i.e., Maple Street, Samaritan House and Safe Harbor) have options for medical treatment or support on site. BHRS and SMMC contract with these three shelters for beds on an annual basis.[35] Private local hospitals also follow the practice of reserving County shelter beds.[36] At the time this report was written, 31 beds were reserved by SMMC, County agencies and private hospitals. While the cost per bed paid by each of these organizations is not available, it is unlikely to approach the high expense of keeping these patients hospitalized.

It is important to note that hospitals' and BHRS' practice of reserving shelter beds bypasses the County's usual procedure for admission to homeless shelters. For a homeless person to access a shelter bed directly*, an in-person interview* at one of HSA's eight Core Service Agencies is required.[37] These agencies are charged with providing various homeless services (e.g., food bank and free grocery options, short term rent and mortgage assistance, utility bill support) but most importantly in this context, are the gateway for entry to County homeless shelters.[38]

[32] The average daily rate of reimbursement to SMMC using Medicare rates is $2,639. Thus the potential lost revenue by having the 37 homeless individuals stay just one day beyond the point when hospitalization is deemed necessary is $102,120. Bill for these days are not reimbursable by any insurer because the patient no longer meets the "medical necessity" requirement. The total number of days recovering homeless were housed in SMMC beds is unknown.

[33] Includes Sutter Health System and Kaiser Permanente hospitals as well as Mills Peninsula Hospital.

[34] LifeMoves is a non-profit organization which operates homeless shelters through California.

[35] Specifically: SMMC reserves five beds at the Maple Street Shelter; BHRS reserves 10 beds for its programs at Maple Street and Samaritan Safe Harbor shelters; WPC grant funds reserve five beds at Maple Street Shelter for their target clients; and County law enforcement can access one bed at Maple Street Shelter, for which they do not pay.

[36] According to HSA interviewee, both Sutter Health System and Mills Peninsula Hospital engage some number of beds at the Samaritan House Shelter. Kaiser Permanente has a contract with the Maple Street Shelter for beds and works directly with shelter staff to refer appropriate ill-homeless patients.

[37] Core Agencies include Resource Centers, several County-run homeless shelters, and a medical clinic serving low income and homeless people across SMC.

[38] Officials from HSA: interview with the Grand Jury.

This interview is a relatively new requirement imposed by the federal Department of Housing and Urban Development for single homeless individuals (such interviews for families experiencing homelessness have been in place for some time). The purpose of the interview is to standardize and prioritize the relative need of individuals seeking County housing resources.[39] Given the variety of County departments that work with the homeless, the County's utilization of a centralized or *Coordinated Entry System (CES)* optimizes fairness and facilitates tracking of shelter use.

Until recently, these in person interviews were only available during office hours (i.e., 9-5, Monday-Friday) at Core Service Agency locations.[40] The interview requirement makes it difficult for homeless without transportation to access Core Service Agencies and even more difficult for homeless individuals recovering from illnesses, surgery or other medical issues. Fortunately, beginning in 2019 the Center on Homelessness, which works with Core Service Agencies in making placements, has begun allowing the ill homeless to apply for County housing benefits while still in the hospital (e.g., SMMC). Building the CES interview into hospital discharge planning greatly smooths the transition from hospitalization to a shelter and recognizes the health concerns of this population.[41]

For the homeless who need some medical support to reach full recovery, the three available shelters for single adults vary in what they can provide. Samaritan House/Safe Harbor are limited to a two-hour visit by the Street Medicine mobile health clinic van[42] on Tuesdays and Thursdays. Constraints include whether or not the patient has the ability to get on and off the vehicle and the need to wait days for appointments. On the other hand, the Maple Street Shelter has a full-time licensed vocational nurse on staff qualified to provide some medical assistance.[43]

The Maple Street Shelter program is the most comprehensive offering in the County and includes not only housing, but mental health, drug and alcohol counseling on site. These are vital services because addiction (alcohol and drug) is the number one problem among the homeless, followed by serious mental illness and by medical issues.[44] Staff at the Maple Street Shelter assist residents in obtaining permanent housing, seeking financial and other benefits for which they are eligible, and reconnecting with friends and family if possible. Maple Street presently houses 141 people with men and women in separate quarters. A new building with greater capacity and improved services is in the planning stages. However, the new shelter was years away from completion even prior to the upheaval caused by COVID-19 to County plans and priorities for the homeless.

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[39] CES is a requirement by the federal Housing and Urban Development (HUD) agency for funding.

[40] Eight Core Service agencies include and are located in: Daly City, Fair Oaks Community Centers; YMCA Community Resource Center (South San Francisco), Pacifica Resource Center, Puente de la Costa Sur (Pescadero), Coastside Hope (El Granada), Samaritan House South (East Palo Alto), and Samaritan House (San Mateo).

[41] Officials from HSA: interview with the Grand Jury.

[42] Street Medicine is a group of medical providers who go into the field to help the homeless. They also run a medical van which provides ambulatory care at homeless shelters and other sites throughout the County on a scheduled basis.

[43] Officials from LifeMoves: interview with the Grand Jury.

[44] Ibid. However, LifeMoves can refuse a potential resident if deemed too ill to be assisted by their staff.

Another important difference among single adult shelters is the hours they are open to their residents. Until recently, Maple Street was the only County shelter open 24/7. Fortunately, Samaritan House/Safe Harbor have followed suit and adopted these hours as well. Allowing recovering homeless to stay housed at the shelter throughout the day as well as the evening (typical of most shelters), greatly improves their recovery prognosis: they are safe, fed, and able to rest without the dangers of living on the street.

Post Hospitalization: New Options for Recovery

Medical Respite/Recuperative Care

In addition to these shelters, a new option is currently being implemented on a pilot basis by the San Mateo Medical Center with funding support from the Health Plan of San Mateo (HPSM) and Measure K revenue. *Medical Respite* or *Recuperative* care provides acute and post-acute medical services for people who are homeless and too ill to be on the street or in a shelter, but not ill enough to be in a hospital.[45] Research suggests that such programs can significantly reduce hospital costs because they act as a deterrent to unnecessary emergency department (ED) re-admission.[46]

Located at a Baden Street site in South San Francisco, this 18-month Recuperative Care pilot project provides the ill homeless sheltered medical care for four-to-six weeks (with an option for extension) in a small residential type environment similar to a Board and Care. When patients are sufficiently recovered, they are released. While a return to homelessness is possible, the program is assisted by a *Care Navigator* who works with County housing resources to secure a suitable housing placement. The Care Navigator position is currently funded by the Whole Person Pilot grant (WPC) described below. The Baden Street pilot will be carefully evaluated by HPSM for cost savings as well as positive patient outcomes and hopefully expanded to full capacity housing up to 15 patients.[47]

A Reimagined Skilled Nursing Facility (SNF) for the Ill Homeless

For many recovering patients, Skilled Nursing Facilities (SNFs) have often filled the need for support between hospitalization and home. This option has not typically been used by homeless individuals because of the expense and the need for help in making the transitions to and from the facility. However, both San Mateo and Santa Clara Counties are exploring variations on the traditional SNF given the high cost and usage of hospital resources by the ill homeless as well as the lack of necessary medical expertise at many shelters.

[45] Healthcare for the Homeless and Farmworker Program, *Annual Report, 2018*.

[46] Ibid.

[47] Officials from HPSM: interview with the Grand Jury.

Two years ago, Santa Clara County's largest hospital (*Valley Medical Center*[48]) began a new program called *PACT: Post- Acute Care Team* initiative.[49] The program targeted patients with complex needs, (including homelessness, fragility due to age, substance use, and mental illness) who no longer require acute hospitalization but lack a safe discharge plan.

Using a multidisciplinary approach that includes Valley Medical Center doctors, social workers and psychologists, PACT coordinates the transition for patients from the hospital to a contracted SNF. Once there, patients are able to access resources related to their medical recovery as well as mental health and substance use treatment, wound care, and information regarding housing and eligibility for other social services. Length of stay varies between two to four months.

The Valley PACT team supervises the treatment of these patients at the SNF to provide continuity of care. Approximately 70% of the 15 PACT beds are used by homeless patients. Once the patient is ready for discharge from the facility, the team develops a plan for patient integration back into the community. According to hospital sources, 130 individuals have participated in PACT to date and about half have been able to find permanent housing.[50]

In addition to securing housing, PACT success is also measured in terms of:

- decreases in hospital length of stay for non-acute patients (by 50%, dropping from 70 to 35 days);
- lower 30-day hospital readmission rate, increased compliance with recommended follow-up care; and
- improved hospital bed capacity (5,000 more hospital bed days were made available).

Overall, Santa Clara County estimates that the program resulted in potential cost avoidance of over $11 million dollars.[51]

San Mateo County began a similar but smaller effort under the auspices of HPSM. Called the *Post-Acute Care Pilot, (PACP)* the program has been functioning for over a year. Six SNFs are under contract for members with Care Advantage, a Medicare/Medi-Cal insurance plan. While currently not accepting homeless patients, this pilot addresses patients similar to the Baden Street Shelter in South San Francisco and Santa Clara County's PACT: medically complex, fragile and usually elderly.

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48 Similar to SMMC, Santa Clara Valley Medical Center is a county owned public hospital serving residents regardless of their ability to pay.

49 Official from Valley Medical Center: interview with the Grand Jury.

50 Using Santa Clara County Measure A Funds.

51 Officials from Valley Medical Center: Interview with Grand Jury and data from https://www.chpso.org/event/making-impact-pact-post-acute-care-transitions-transitions-care-model-vulnerable-patients.

An HPSM-paid physician with training in gerontology and an experienced nurse practitioner work with these patients during their stay at the SNFs. Follow up at home is provided if needed, including continuing coordination with the hospital discharge staff and the patient's primary care physician. Discussion with plan representatives suggests if the pilot is successful, the model may be extended to other similar populations such as the ill homeless.[52]

Given the success of Santa Clara County's PACT as well as early positive feedback from HPSM's PACP and Baden Street pilot programs, there appears to be merit in post-hospitalization placements that combine medical follow-up care with supportive housing. At this point, what is required is the development of a *comprehensive medical respite plan for the County's ill homeless.* Such a plan should evaluate current County efforts in terms of cost and effectiveness with an appreciation of the complexities of the homeless population and their needs. According to their most recent annual report, the creation of such a plan was a priority of the County's Healthcare for the Homeless and Farmworker program, in conjunction with the *Hospital Consortium of San Mateo County*.[53]

The Hospital Consortium of San Mateo County is a small but influential non-profit organization whose member hospitals include: Seton, Mills Peninsula, Sequoia, Kaiser Permanente (RWC) hospitals as well as SMMC. Stanford Hospital is invited and attends the group's meetings even though their main hospital is located in Palo Alto (Santa Clara County) because they have a large hospital clinic in Redwood City.

The Consortium's purpose is to address issues of common concern among hospitals, develop joint programs (such as Continuing Medical Education options for staff) and support mutual problem solving. As set forth in the Consortium's annual report, this group, plus the representatives from Healthcare for the Homeless and Farmworkers Program and key stakeholders from County medical, behavioral health and housing agencies would be well suited to develop a viable respite care plan for the ill homeless. However, under the constraints of COVID-19, it is unknown when the Consortium and others will be able to convene and pursue this project.

The diagram below summarizes the journey of a homeless patient whose condition required hospitalization but has no secure home or housing in which to make a complete recovery.

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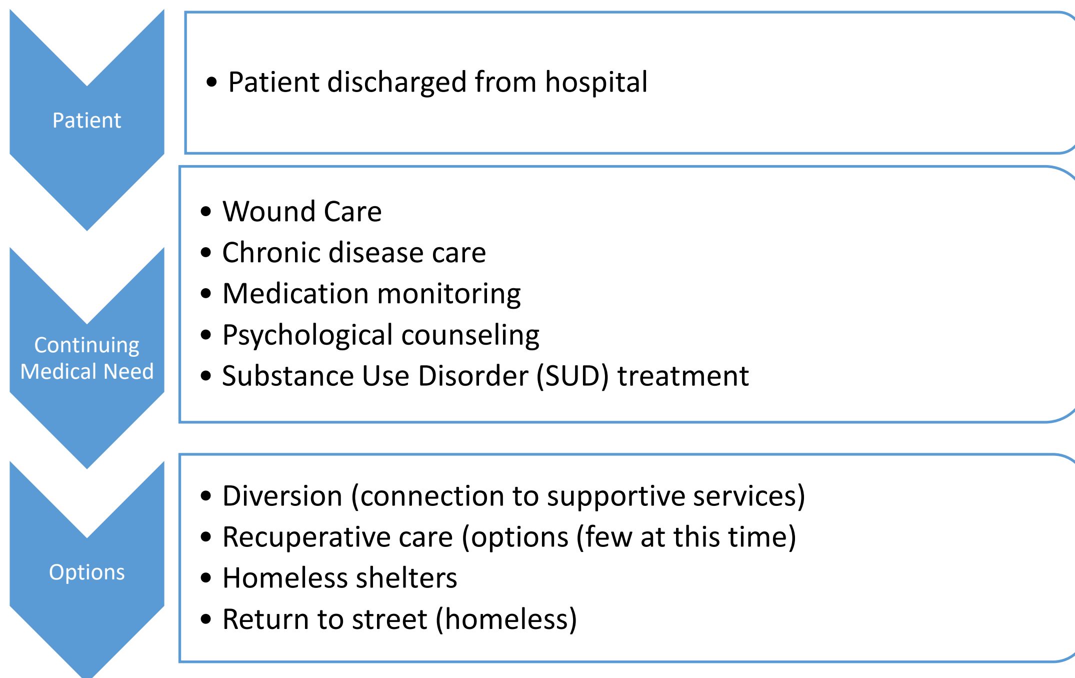
52 Ibid.

53 Health Care for the Homeless & Farmworker Health Program, *Annual Report 2018.*



Section 5: Innovation in Ill Homeless Care- The Whole Person Care Pilot

In 2015, San Mateo County received a five-year $82 million grant funded by the Centers for Medicare as well as State and County matching funds for the Whole Person Care Pilot (WPC),.[54] After two years of planning, program implementation began in 2017 and will end in December 2020.[55] The objective was to create opportunities for local communities (i.e., counties) to develop programs to coordinate physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries. Of particular interest were individuals who were high users of multiple health care systems, especially numerous and expensive emergency department (ED) visits, who still have poor health outcomes.

While the homeless can become ill because of any disease or illness, they are equally or even more greatly impacted by the "social determinants of health."[56] These include poverty, lack of preventive care, poor nutrition and risky lifestyle choices such as smoking, abusing alcohol or drugs that negatively affect health. WPC pilots, such as that in San Mateo County, were asked to develop programs to focus on the "whole person" by providing patients with necessary health care PLUS "wrap around services" addressing comorbid conditions as noted above. The overall goals were better health at a lower cost for MediCare/Medi-Cal.

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54 Section 1115 Medical Waiver "Medi-Cal 2020."

55 Whole Person Care Pilot Grant (WPC), 1-58.

56 Robert A. Hahn, "Two Paths to Health in all Policies: The Traditional Public Health Path and the Path of Social Determinants," *American Journal of Public Health*, Vol 109, No. 2 (2019): 253-254.

The SMC WPC project involved 16 County agencies and community partners led by the San Mateo County Health System (SMCHS). These entities provide medical/behavioral health, recovery services, and housing and are listed below:

Medical/Behavioral Partners: the County's Department of Public Health, Policy and Planning (Public Health) and the Institute on Aging as well as HPSM, Stanford Medical Center and Clinics, Behavioral Health and Recovery Service (BHRS), and Correctional Health Services;

Recovery Partners (focusing on substance abuses and mental health): HealthRIGHT 360, Heart and Soul, Horizon Services, StarVista, Voices of Recovery; and

Housing Partners: Brilliant Corners, LifeMoves, San Mateo County Department of Housing (DH), as well as San Mateo County Human Services Agency (HSA).

Participation by HPSM provides a significant advantage to the WPC effort. The Plan is one of very few health insurance entities in the State of California that provides services to ALL Medi-Cal eligible County residents. Having one insurer/payer for all targeted participants and all reimbursable health services greatly simplified this healthcare collaboration since there was no need to negotiate contracts with multiple insurers and health care delivery plans.

In order to be eligible for participation in the WPC project, individuals must have had at least four emergency department visits within a 12-month period.[57] Approximately 1,800 HPSM clients met the ED visit criterion and included individuals with complex medical issues as well as mental and substance abuse comorbidities. Within this group, approximately 220 *homeless* patients who reported very high usage of the ED or psychiatric emergency services were invited to participate at the start of the program.[58]. After two years of planning and establishing various County inter-agency agreements, the following WPC programs benefiting the ill homeless were initiated.

WPC Funded Outreach Healthcare Programs

As noted, many homeless are poorly connected to primary care or behavioral health providers and are reluctant to seek assistance in regular medical clinical settings. Therefore, WPC funds were used to improve or extend existing outreach programs as well as develop new initiatives in order to bring healthcare directly to the environments where the homeless live.[59]

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[57] Patients were grouped into those with 1) mental illnesses, 2) SUD issues, and 3) these issues plus homelessness.

[58] There is much turnover of clients in the WPC pilot: homeless become participants and then drop out for a myriad of reasons, some of which will be discussed later in the report.

[59] Whole Person Care Pilot Grant (WPC), 7-8.

The first such program is an expansion of the existing HOT team program run through LifeMoves, called *Community Health Outreach Workers or (CHOW).*[60] Like HOT, CHOW team members go into the community to identify and help ill homeless. These individuals were trained in relationship building and methods to encourage trust with the goals of linking the homeless to acute care options and eventually to housing services.

The second program, the original Street Medicine Team (funded by the County's Public Health, Policy and Planning Department) used WPC funds to develop an expansion of the *Bridges to Wellness Team (BWT).*[61] This group now includes integrated psychiatric support as well as standard field-based medical care, access to a Mobile Health Clinic Van, and coordination of medical and non-medical services. Both Street Medicine and Bridges to Wellness work with the HOT/CHOW teams to re-establish connections to the clients' primary care and behavioral health providers and housing services. Some Bridges to Wellness team members are designated as *Bridges to Wellness Team Resiliency Specialists* with the responsibility to teach the ill homeless self-management of conditions ranging from depression, hypertension, diabetes and other chronic conditions.

Peer support was identified by the WPC as a key element to improving healthcare outcomes for homeless participants. "Care Navigators" is the third program funded by WPC to incorporate this element.[62] "Navigators" are individuals who had personally experienced and recovered from drug or alcohol abuse, mental illness, or homelessness. Because of their similar backgrounds, Care Navigators could more quickly build personal connections to current homeless and act as plausible examples of rehabilitation. As peers, Peer Navigators work in all aspects of the WPC with the target populations (high ED users with substance abuse, mental health issues and individuals who suffer from these issues as well as homelessness).

In terms of the ill homeless, some Care Navigators provide peer support for homeless individuals in a variety of settings. For example, at the Baden Street Shelter recuperative care pilot program a Peer Navigator assists ready to be discharged homeless to connect with housing and other services for ongoing needs. Other Navigators provide service and care coordination across County health and social services departments. Given the many agencies and departments involved with the ill homeless, this coordination is vital to ensure that clients are able to access the treatment they need, and that up-to-date information is shared with all of their providers.

Finally using WPC funds, BHRS created a *Psychiatric Emergency Response Team, (PERT*).[63] This outreach team of mental health workers collaborates with law enforcement officers when a potentially violent mental health crisis situation develops with a homeless individual in the field.

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[60] CHOW: Expansion of the HOT, this team identifies homeless in the field and links homeless individuals to County services.

[61] BWT: Expansion of the Street Medicine Team, this team adds psychiatric support to standard field-based medical care.

[62] Care Navigators: Peer role models who have recovered from addiction, mental health and/or homeless issues who connect current homeless to services.

[63] PERT: Trained psychiatric workers who team up with Sheriff deputies to help the homeless.

PERT personnel attempt to de-escalate the interaction so the disturbed person is brought into treatment and not incarcerated.

In sum, the WPC greatly expanded available outreach personnel and programs to assist the homeless community. Funding was used to connect ill homeless to the level of medical care they required, offer skills training classes to support self-management, provide peer mentors, integrated psychiatric care into outreach teams, and improve care coordination across participating agencies.[64]

Note, the programs thus described focus on the ill homeless; similar efforts are run by the WPC for those participants whose primary presenting problem is SUD or psychiatric issues. The "outreach" function (e.g., HOT/CHOW) "reaches" all patient types and attempts to bring them into whatever type(s) of treatment required. Care Navigators are more differentiated because they are (trained) peers who have overcome SUD, mental health and homelessness, and they use their expertise to support patients within the SUD or mental health recovery agencies. Some of their clients may become homeless over the course of the pilot. Homeless clients are hopefully placed into housing at some point using WPC resources and connections. In other words, the WPC clients do not fit neatly into categories although for the purposes of data analysis and outcome evaluation, they are so grouped.

WPC Data Infrastructure Integration

Effectively helping the ill homeless involves staff and programs from multiple County departments and community partners, each with their own method of tracking patient care and use of services. Thus, a key goal of the WPC was to develop a comprehensive data system that integrated information from these different agencies. Two key aspects of this complex effort include a "*Health Information Exchange,"* created to support care coordination by medical and agency staff members, and an "*Enterprise Data Warehouse*," designed to combine patient medical data with housing and social services information for the purpose of ongoing program evaluation and data analytics.[65]

Specifically, the WPC project envisioned linking four different types of data for each patient in the Health Information Exchange (HIE):[66]

- health record information (from SMMC and mobile health outreach encounters);
- behavioral health records (from BHRS, SMMC and outreach encounters);
- Medi-Cal eligibility (from HPSM); and
- usage of other social services such as housing vouchers, food stamps, and shelter stays (from HSA and the Department of Housing).

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64 Whole Person Care Pilot Grant (WPC), 8-11, 20-21.

65 Ibid.

66 From the WPC Pilot grant proposal: "…the development of the HIE and all its functions will enable care managers and clinicians to have immediate, seamless information that has been historically siloed and unavailable. This access to information will streamline operations and facilitate coordinated care that long has been the dream of most medical, behavioral, and social science professions…the HIE will save lives that are too often lost due to lack of access to health and medical information in real time."

Having these data available in one place would improve individual patient care via early intervention, provide documentation of services and provide all care providers with a comprehensive overview of patient treatments across agencies. The Health Information Exchange also lays the groundwork for building the Data Warehouse.

When completed this Data Warehouse will contain an inclusive longitudinal data set of WPC patient demographics, treatment experiences and health outcomes. Among many possible uses, these data can be analyzed to develop predictive algorithms for identifying individuals whose pattern of health issues and health care usage predict *future* high-risk, including probable use of expensive emergency rooms and/or psychiatric hospitalization. If such individuals could be identified by appropriate algorithms and *treated before they need intense medical interventions*, an improvement in their health and reduction in healthcare costs could be achieved.

WPC Support for Housing

California has some of the worst housing shortages in the country with resulting high rents. Medi-Cal and the WPC do not provide a direct funding solution for ill homeless individuals needing accommodation because their funds cannot be used for purchasing or acquiring rental housing. However, the San Mateo WPC project developed some housing support programs that could be covered with grant funds as described below.[67]

In addition to personal wellness and health management classes, LifeMoves and Bridges to Wellness teams offer skills training instruction in housing readiness and self-management with the goal of helping the homeless successfully live in standard housing. Topics include bill paying, managing a bank account, nutrition and options for acquiring food. These teams also intervene with landlords or roommates and assist with Section 8 housing vouchers (which might expire during hospitalization or for some other reason, not renewed). If a client is medically stable, collaboration is arranged with Bright Corners, the WPC partner responsible for providing housing options with supportive services.

To date, the WPC project has funded approximately 220 motel night stays for 20 ill homeless participants. The motel stays have not only provided a clean and safe place to recover from hospitalization but also helped fragile clients become more likely to follow-up with primary care appointments and take necessary medications improving the chances of a full recovery.[68]

WPC Project Status

As noted, the ultimate success of the WPC is yet to be evaluated (grant funding ends December 2020). However, there are three primary sources that document the WPC's progress to date. The WPC requires semi-annual and annual reports to be written by the WPC leadership group to demonstrate progress and identify problems in order to justify continued funding. As such, the first two sources are the "State of California, Department of Health Care Services *Whole Person Care Lead Entity Mid-Year Narrative Report"* dated September 6, 2019 and the May 1, 2020

[67] Whole Person Care Pilot Grant (WPC), 22-23.

[68] WPC Semi-Annual Progress Report Year 4 and the Year 4 Annual Narrative Report.

Annual Narrative Report.[69] The findings of these two most recent reports are summarized below.

WPC September 2019 Mid-Year Report and May 2020 Annual Report

Key Advances
These evaluation reports noted significant progress in helping more ill homeless off the streets and treating them in non-emergency care settings (e.g., mobile clinic van, primary care, medical clinics), establishing two recuperative care pilot studies (i.e., creation of the Baden Street Shelter and Post-Acute Care Pilot), and improving coordination of care across medical and behavioral health systems. For example, within SMMC, *Warm Hand-Off* was created to assist patients using high intensity services transition to lower intensity and therefore, less expensive support.[70] The Annual report noted that while the number of visits to the ED showed a slight reduction in usage, the actual number of days the homeless spent in the SMMC was somewhat higher.[71] Considerable efforts were made in staff training across all partners to improve client engagement (i.e., motivational interviewing techniques) and improve clinician expertise using evidence based treatments.

Regarding data infrastructure development, the reports noted progress had been made in developing partner agreements necessary to create the integrated data warehouse; establishing longitudinal personal health records for clients; and implementing staff training in entering patient data from smart phones when treatment was administered in the field as well as the increased use of integrated data dashboards by medical professionals. Patient clinical data sharing was expanded to more participating WPC agencies.

Key Challenges
Data Systems Irregularities: The two required reports noted ongoing challenges related to differing quality of the data sets maintained by County departments and Health System divisions including BHRS, HSA, Correctional Health, the Department of Housing, and the Division of Public Health, Policy and Planning, as well as community partners. Some agencies were still operating with paper records and others had varying data set ups and tolerances for amounts of missing data and errors. These types of issues are not uncommon when entities attempt data integration across different technology platforms.

However, there were some non-technical problems that impacted comprehensive database completion. Among these issues was the difficulty in accessing client level data for substance use disorder care coordination due to 42 CFR-Part 2 confidentiality requirements and limits on sharing mental health data due to confidentiality requirements.[72]

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69 Ibid.

70 As an example, primary care personnel would meet patients and their physicians in the ED or during hospital discharge to become acquainted with their medical requirements and to set up necessary follow-up visits.

71 Authority: 42 U.S.C.290-2. SOURCE 82 FR 6115, Jan. 18 2017 unless otherwise noted.

72 HIPPA: Health Insurance Portability and Accountability Act (1996) protects sensitive health information from being disclosed without patient consent or knowledge. This includes treatment for substance abuse.

Confidentiality of Treatment for Substance Use Disorder (SUD): Federal confidentiality laws specifically protect the privacy of SUD patients by prohibiting unauthorized disclosures of SUD treatment except in limited circumstances.[73] Given that substance use disorders are so prevalent among the ill homeless, the lack of ability to track their treatment for these problems puts their overall recovery and successful use of other WPC resources in jeopardy. Other counties involved in the California WPC project have found means to obtain SUD data despite this law, so it is hoped that the San Mateo County project will eventually find a means to include this key data point in the Enterprise Data Warehouse.[74]

Maintaining Eligibility for Health Care Benefits: Another ongoing challenge reported was the fact that some health system agencies'[75] access to patient Medi-Cal eligibility status is restricted, thus blocking insurance verification. This problem occurs because Medi-Cal eligibility is determined by the State and beneficiaries' names and eligibility statuses are sent only to the County HSA. In turn HSA is limited to sharing this information both with its Center on Homelessness as well as its private partners (i.e., the eight Core Agencies).

Once deemed eligible for Medi-Cal benefits by the State, the usual procedure is for covered individuals to choose and enroll in a health insurance plan (in the County, the only choice is HPSM). As discussed, the ill homeless are often poorly motivated or equipped to be proactive in this regard. They are also thwarted because Medi-Cal requires beneficiaries to have a home address. Since by definition, the homeless do not have a "home address," they improvise by listing the address of the SMMC, a homeless shelter, or someone they know. The lack of permanent address increases the likelihood that even once enrolled, they may lose eligibility because they do not get renewal information or lose paperwork that document their benefits.

In terms of the WPC project, approximately 50-60 of their participating patients are dropped from Medi-Cal every month and as a result, from the WPC and services. This obtaining and losing benefits is called "*Medi-Cal churn.*"[76]

Currently various "work around processes" have been put in place so that HPSM can more easily identify ill homeless clients dropped by Medi-Cal and as result, from the WPC. Among these strategies are asking clients to sign authorized releases of their eligibility status which can be given to HPSM and other health system staff as well as co-locating HSA and HPSM personnel in office space so some limited information can be shared, and the client can be prompted to re-establish benefits.[77]

This is a significant data disconnect that the WPC pilot had been designed to ameliorate. At the time this Grand Jury report was written, the Annual Report noted that a "Memorandum of Understanding" (MOU) had been written between the HSA's Center on Homelessness and HPSM to allow some increased access to patient insurance eligibility information. Ironically, the

[73] 42 CFR-Part 2

[74] Ibid. For example having clients sign treatment release forms – perhaps electronically in the field.

[75] SMMC, HPSM, other county clinics

[76] Official from WPC Pilot Program: interview with the Grand Jury.

[77] Ibid.

trauma of the COVID-19 crisis may help this connection to be made under emergency measures currently being considered by the federal Secretary of Health and Human Services.[78]

Report from the National Evaluator of WPC Pilot Projects

The third source of information regarding the County's WPC status-to-date is a research brief written by the *UCLA Center for Health Policy Research*.[79] The Center is the program evaluator for WPC Pilot projects across the nation.

In comparison to other WPC efforts in the State, the County's WPC pilot lags behind with regard to "data sharing capabilities to support care coordination." In particular, the project did not achieve "electronic capture of comprehensive care plans," or the ability of frontline staff to electronically track, record or access these data. Perhaps relatedly, the County pilot fell short in developing standardized protocols for monitoring clients across participating service entities as well as developing annual patient needs assessments and creating shared treatment plans.[80]

These shortcomings may be addressed in the remaining term of the WPC and if incomplete, hopefully will be included as a priority in the pilot's "Sustainability Plan" for program maintenance after the original funding ends. This Sustainability Plan, bolstered by the County's WPC project data as well as comparative information from other California WPC pilots, should provide a strong empirical foundation of "best practices" for addressing the future needs of the County's ill homeless.

A POTENTIAL EXPLOSION OF HOMELESSNESS?

The WPC's infusion of $82 million dollars (slated to end in 2020) cannot easily be replaced: more than 70 personnel were hired, and significant grant overhead monies as well as "pay for performance" bonuses were provided to participating agencies. It was initially expected that the Governor's original State budget (2020-21) would provide replacement funding to fight homelessness and expand Medi-Cal services.[81]

Specifically, the Governor's proposed housing plans included tenancy support services, housing navigation services, and recuperative care – all of which were explicitly piloted in the WPC thus putting the County in an excellent position to use their experience and quickly implement well tested interventions. However, COVID-19 has brought a dramatic change to governmental priorities by decimating the State budget, tax revenues and its reserve.[82] Maintenance of California's healthcare systems and economy for all residents have become front and foremost concerns.

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[78] See Appendix B for more information on Federal changes to Medi-Cal due to COVID.

[79] Emmeline, Chuang, Brenna, O'Masta, Elaine, Albertson, Leigh Ann Haley, Connie Lu, Pourat, "Whole Person Care Improves Care Coordination for Many Californians," Los Angeles, CA: UCLA Center of Health Policy Research, 2019, 1-10.

[80] Ibid.

[81] Governor's Budget Summary 2020-21, http://www.ebudget.ca.gov/20201/pdf/BudgetSummary/Homelessness.pdf, accessed May 28, 2020.

[82] Ibid.

At the present time, the Grand Jury cannot estimate the impact of the COVID-19 virus on the current homeless population and future spending.[83] What is certain, however, is that the problem of homelessness and the ill individuals among them, will not go away. Indeed, it is likely that the number of unsheltered people living in SMC will increase.

Based on 2017 census data obtained from DATA USA regarding the number of SMC residents *who live below the federal poverty line,*[84] approximately 7.3% of the total County population met this criterion. With a total population of about 757,000, this percentage indicates that approximately 55,000 residents are at the edge of poverty. Demographically, more women than men are at risk: highest percentages were seen in women ages 25-34 followed by age 35-44, and then men ages 25-34. Five percent of those living on the edge of poverty were women over age 75.

The elderly women in this group are likely to be living with others and/or supported by modest Social Security and other such retirement benefits. On the other hand, men and women in the 25-44 age ranges are probably low paid, non-salaried workers (i.e., employed in minimum wage jobs or less) and are likely to be vulnerable to loss of employment in the current economic situation. These groups are most at risk for *future homelessness* and resulting poor health within the County.

Alarmingly even prior to the pandemic, the WPC reported that the ill homeless participants died at three to six times the rate of their housed peers.[85] Given the double hit of COVID-19 and the economic slowdown, *the County may expect a severe increase in the number of residents who slide into poverty, homelessness, and potentially illness and death.*

Now is the time for San Mateo County to assess why *everyone* is working on homelessness, at what cost and to what effect. With resources likely to be strained for the foreseeable future, it is vital that the current overlapping, confusing, expensive conglomerate of services be re-evaluated with the goals of finding synergies and efficiencies. The following section summarizes the key findings of this investigation and recommendations critical to addressing the County's current, and likely increasing, problem of caring for our vulnerable homeless population.

FINDINGS

F1. There is no County department or division, which coordinates the County's efforts to comprehensively address the issues faced by the homeless or ill subset. Currently, the County has at least seven departments or divisions – including HSA, the Department of Housing, SMMC, the Division of Public Health, Policy, and Planning, BHRS, and the Sheriff's Office – involved in some part of the lives of ill homeless people.

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83 The Governor has suggested that "private wealth" step up to help fill the funding gap in homeless services; see Appendix A.

84 Census Bureau ACS-5 year estimate (2017). https://datausa.io/profile/geo/san-mateo-county-ca#economy, retrieved 8/13/2020

85 Grand Jury Interview. Data varied depending on which semi-annual or annual report was analyzed.

F2. City police officers with duties as Homeless Outreach Coordinators and County Sheriff's deputies who work with the Psychiatric Emergency Response Team (PERT) play a significant role in identifying the homeless, de-escalating potential conflict involving the homeless, and linking the homeless to services, including providing transportation to medical treatment entities and shelters. Some police have been trained by BHRS to work with outreach teams in the field to help deal with homeless who may be a danger to themselves or others.

F3. Determining the financial cost to the County for treating the ill homeless is extremely difficult given the various treatment alternatives (e.g., hospitals, clinics, vans, shelters, respite care options and care delivered "on the street.") and other programs which are managed across numerous County departments and divisions. The County's Budget, Policy, and Performance unit estimated that approximately $54 million dollars was directed by the County to help ameliorate homelessness in 2019. According to the latest housing census, there were 1,512 homeless individuals in SMC.

F4. The County invests heavily in outreach teams within and across agencies for finding the ill homeless and linking them to necessary treatment before hospitalization is required. However, it is not clearly set forth on any public website or document how these teams coordinate or interact or how their effectiveness is determined.

F5. Of the discharge housing options available, there is a lack of appropriate shelter for individuals who are well enough to leave the hospital but still require some help to recover fully. Several County organizations, including HPSM, are funding various pilot studies for "respite" or "recuperative" care that show promise to meet this need. However, at this point, the County lacks a comprehensive plan for this service.

F6. There is only one County shelter (Maple Street) that has a nurse on staff to provide a level of health care support for ill and recovering homeless. Grand Jury interviews revealed staff are sometimes put in the difficult position of having to decide to take or refuse some ill homeless patient due to their very precarious health status. Only Maple Street and two other single adult shelters are now open to residents 24/7 which allows the ill homeless a safe, clean environment to sleep and recover from illness.

F7. Most hospitals in the County, BHRS and WPC reserve (and pay for) beds at Maple Street Shelter or Samaritan House for their homeless patients requiring recuperative care. There is a lack of consistency in how to access these beds: some entities use the County's Coordinated Entry System while others are able to by-pass this risk assessment interview. There are no data evaluating the cost effectiveness of this strategy in terms of county funding or agreement about the cost paid by different entities for these beds.

F8. The County is in the planning stages for relocating and rebuilding the Maple Street Shelter. This will provide the County with an opportunity to reassess the needs of the homeless in general and the ill-homeless in particular. The ill homeless are complex, suffering from a variety of physical and mental disorders which impact their ability to access and maintain

housing. Female homeless individuals and the elderly are especially at risk for future homelessness and resulting poor health.

F9. Beginning in 2015, the Medicare/Medi-Cal funded "Whole Person Care Pilot" (WPC) project offered an opportunity and significant funding for SMC to develop an integrated health care plan for vulnerable individuals, including the ill homeless. As a result of WPC, the County began implementing significantly improved collaboration among partners and developing of new programs as well as expanding existing programs for treating the target populations.

F10. WPC goals related to addressing Medi-Cal churn as well as HIPAA confidentiality concerns have not yet been achieved. Furthermore, The County's WPC project lags behind other counties with regard to data sharing capabilities to support care coordination.

F11. In order to receive and maintain Medi-Cal benefits, a home address is required. By definition, the homeless do not have one, so they substitute temporary locations such as the SMMC, shelters, or someone else's address. As a result, homeless individuals often do not receive important insurance and medical documents and become uninsured. This causes a critical gap which results in potentially insurable patients not being treated or the County health services unable to obtain reimbursement.

F12. Within the County, there is a lack of affordable permanent housing of various types (e.g., Board and Care type facilities, supervised group homes, single room occupancy hotels) for the homeless with chronic or long- term conditions that require support (e.g., stable mental illness, diabetes, cancer, heart disease). Without such options, the ill homeless will likely recycle back into encampments or the streets and again rely on emergency departments for needed treatment obviating any reduction in health care savings.

F13. While the County should be applauded for reaching out to grant agencies for funding programs that support the ill homeless, it appears that such programs may not be sustainable after grant funding ends. Given that the County support system is already complex, the addition and subtraction of pilot programs without institutionalization provides only a finger in the dike and potentially adds to client and provider confusion about resources.

RECOMMENDATIONS

Regarding Pre-Hospitalization

R1. The County Board of Supervisors (BOS) should direct the County Manager to develop a clear outline of the departments, agencies, and community partners who receive county funds involved in assisting the homeless and the specific subset of the ill homeless focusing on points of overlap and duplication of services. The Board should also direct the County Manager to report back to the Board in a public meeting, what efforts are being undertaken to better coordinate County efforts and potentially reduce bureaucracy and costs. This report from the County Manager should be publicly presented to the Board by December 31, 2020.

R2. The BOS should direct the County's Budget, Policy, and Performance unit to annually determine the actual costs for helping the homeless and the specific subset of the ill homeless to the County by December 31, 2020.

R3. Because the homeless move from place to place, the BOS should request that the County Sheriff and Police Chiefs convene a task force to increase cross-jurisdictional coordination and communication. As part of this collaboration, they should determine if the number and training of officers is sufficient to address homeless outreach and crisis management in those localities where homelessness is the biggest problem. The task force should hold an initial meeting by December 31, 2020 and regularly thereafter to exchange information and best practices.

Regarding hospitalization, discharge options and SB 1152

R4. By June 30, 2021, the County's Human Services Agency (HSA) should collaborate with the Governing Board of the Health Plan of San Mateo (HPSM) to create a standard option as a housing address proxy for the homeless and ill homeless so County hospitals and services can be reimbursed for services.

R5. The County should develop a comprehensive plan for medical respite/recuperative care for the ill homeless by including key representatives from appropriate County departments to collaborate with the Health Care for the Homeless and Farmworker Program and the Hospital Consortium by June 20, 2021.

R6. HSA should allow the CES assessment to be more available outside of normal business hours and standardize its inclusion into all hospital or shelter discharge plans by October 31, 2020.

R7. The County should conduct an overall evaluation of the County's homeless shelters through the lens of the ill homeless, e.g., ability to assist with a range of medical needs and 24/7 availability of housing by June 30, 2021.

R8. In the planned design and rebuilding of the Maple Street Shelter, the BOS should direct the County Manager to work with departments to prioritize addressing the needs of ill homeless, especially vulnerable women and the elderly by December 31, 2020.

R9. The County's Department of Housing should evaluate the feasibility of securing added board and care type housing facilities to provide long-term care, staffed with appropriate medical personnel, for homeless with chronic medical and mental illness needs by December 31, 2020.

Regarding WPC

R10. The County Manager's Office should work with the relevant County departments to determine if it is possible to permanently fund the integration of psychiatric personnel into all outreach efforts/teams given the high presence of mental health issues among the

homeless, and should have the relevant County departments publicly report the results of this effort to the Board during a regularly scheduled Board meeting by March 31, 2021.

R11. The County Manager should prioritize the completion of the integrated data systems (i.e., Health Information Exchange and Enterprise Data Warehouse) which were begun under the auspices of the WPC and report back to the Board in a public meeting by December 31, 2020, whether the funding of such integration is possible and, if so, by which date it will be completed.

REQUEST FOR RESPONSES

Pursuant to Penal Code Section 933.05, the Grand Jury requests responses within 90 days from the following:

- County Board of Supervisors: R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11

The governing bodies indicated above should be aware that the comment or response of the governing body must be conducted subject to the notice, agenda, and open meeting requirements of the Brown Act.

METHODOLOGY

Documents

- Reviewed the 2017 and 2019 San Mateo County One Day Homeless Count and Survey which identified and categorized the homeless in the County.
- Reviewed the Whole Person Care grant proposal and Mid-Year 4 and Year 4 Annual progress reports.
- Reviewed the 2014-2014 Marin County Grand Jury Report "Homeless in Marin-A Call for Leadership," Public Release Date: April 23, 2015.
- Reviewed the Policy Guidelines of the San Mateo Medical System "Discharge and Transfer" which outlines compliance guidelines for SB 1152 for homeless patients (02/27/2020).
- Reviewed San Mateo County Health Care for the Homeless and Farmworker Health Program 2018 Annual Report.

Site Tours

- Visited the Maple Street Shelter, San Mateo Medical Center and Santa Clara Valley Medical Center.

Interviews

Reports issued by the Civil Grand Jury do not identify individuals interviewed. Penal Code Section 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Civil Grand Jury.

During the course of the investigation, the Grand Jury conducted 24 interviews including meetings with representatives from:

- Multiple County departments involved with health and/or the homeless
- Police officers
- Homeless shelter staff members
- A Health Maintenance Organization
- A community organization serving many of the County's homeless including providing shelter beds
- A representative from the Whole Person Care (WPC) grant
- Personnel from three area hospitals including San Mateo Medical Center, Stanford Hospital and Santa Clara County's Valley Medical Center.

The Grand Jury identified the following San Mateo County agencies as significantly interacting with the ill homeless:

- City Police and Sheriff's officers
- The San Mateo Medical Center (SMMC)
- Behavioral and Human Recovery Services (BHRS)
- Department of Public Health, Policy and Planning
- Human Services Agency (HSA) Department's '"Core Agencies" (including Samaritan House, the lead of the Core) and the Center on Homelessness
- The Health Care for the Homeless Program and Farmworker Program
- The Hospital Consortium
- The Health Plan of San Mateo (HPSM)

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APPENDIX A: CONSIDERING PHILANTHROPY AS A SOURCE OF FUNDING

Accepting the new realities of County funding for even sustaining existing homeless services, following the Governor's suggestion that *private philanthropy* could support the State's homelessness priorities, may be a timely and expedient approach.[86] Given the County's location in Silicon Valley and the many residents who hold some of the best paying jobs in the country, it may behoove the County to aggressively pursue such charitable giving.

The County has at least one mechanism to accept philanthropic gifts for homeless relief. The Center on Homelessness operates the *San Mateo County Homeless Fund.* It is not known what effort is put into fund raising or how much endowment has been acquired by this entity. But there is potential. For example, UCSF recently received $30 million dollars from Marc Benioff, the billionaire founder of Salesforce, to create the *Benioff Homelessness Initiative*. The stated goals include translating proven homeless solutions into widespread adoption and researching the underlying causes and consequences of homelessness.[87]

Another funding strategy might employ the expertise of the SMC Hospital Consortium. Interviews with Stanford Hospital personnel revealed private fundraising provides significant resources for medical and wrap-around services for the ill homeless who use their ED. Such monies supply social worker staff 24/7 to assist homeless people in meeting their needs.

Finally, strategies and methods for raising private funds might be added as an agenda item in developing the Grand Jury proposed comprehensive plan for homeless recuperative care to be developed under the supervision of the Board of Supervisors.

[86] Analysis of State Budget 2020-2021.

[87] Silver Lumsdaine & Mike Billings, "New Benioff Homeless Initiative to Turn Research into Action, May 2,2019,https://www.ucsf.edu/news/2019/05/414396/new-benioff-homelessness-initiative-turn-research-action

APPENDIX B: FEDERAL EMERGENCY MEDICAID MEASURES DUE TO COVID-19

The federal Health and Human Services agency (HHS) can utilize its emergency powers to help state Medicaid programs in times of crisis under section 1135 of the Social Security Act. This Act went into effect upon the President's declaration of a COVID-19 national emergency on March 13, 2020.

The State of California may also request that the national Centers for Medicare & Medicaid (CMS) *delay or suspend Medicaid eligibility renewals and terminations* making it easier to keep people insured.[88] For example, California can provide enrollees with more time to respond to renewal information requests, accept self-attestation of income, or temporarily waive certain verification requirements, without having to document exceptions on a case-by-case basis. Adopting this policy would encourage individuals to seek care without concerns about the status of their health coverage. It also helps ensure the provider system receives reimbursement for services delivered to patients impacted by this crisis.

The State of California can also seek a federal waiver to *expand the use of presumptive eligibility.* This provides temporary Medicaid coverage to individuals who are likely eligible, expands the number and type of entities accepting Medicaid, and allows an expedited and/or abbreviated patient application process for benefits.

Adopting these two policies not only aids in the immediate COVID-19 crisis but if continued would reduce Medi-Cal churning, thus improving medical treatment of the homeless in San Mateo County far into the future.[89]

As of the date of this report, the State of California has sought and received these accommodations for Medi-Cal beneficiaries. Despite the bleak conditions which these actions were initiated, ***only positive outcomes can result for the ill homeless.***

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[88] As of March 18, 2020, this Federal waiver was granted for COVID-19 diagnosis and treatment of Medi-Cal eligible patients. (dhcs.ca.gov/services/medi-cal/eligibility/Pages/COVID-19-Presumptive-Eligibility-Program.aspx)

APPENDIX C: TABLE FORMAT OF WPC INVOLVED AGENCIES AND PROGRAMS

AGENCY	DEPARTMENT	PROGRAM
SMC Housing Agencies	Department of Housing (DH) -Human Services Agency (HSA) -Core Agencies (8) -Center on Homelessness	WPC Partner Shelters and homeless outreach Programs/supports Biennial Homeless Census & Homeless Engagement Assessment and Linkage (HEAL), Diversion Coordinator Pilot
SMC Medical Organizations	SMC Health System (SMCHS) San Mateo Medical Center (SMMC) Public Health Policy & Planning (PHPP) The Health Plan of San Mateo (HPSM)	WPC Coordinating Team Diversion Coordinators & Peer Navigators Mobile Health Clinic/Van Street Medicine Team Pilot Projects: Baden Street Shelter & Post -Acute Care (PACP)
SMC Behavioral/Mental Health Agencies	Behavioral Health and Recovery Services (BHRS)	Homeless Outreach Team (HOT) funder Provider of Board and Care placement for psychiatric homeless
Community Agencies: Substance Abuse	Star Vista Voices of Recovery Heart and Soul Horizon Services Health Right 360	Drug, Alcohol & Mental Illness treatment
Community Agencies: Housing	LiveMoves Brilliant Corners	Homeless Out Reach Team (HOT) & Maple Street Shelter Supportive Housing
County Law Enforcement	Correctional Health Services (CHS) City Police Depts. & Sheriff Office	Psychiatric Emergency Response Team (PERT) Homeless Outreach Coordinators
Whole Person Care Pilot (WPC) Initiated Programs for Ill Homeless	16 County Agencies/Community Partners	Community Health Outreach Workers (CHOW) Bridges to Wellness Team (BTW) BTW Resiliency Specialists Care Navigators/Mentors in Discharge (Peer Mentors) Psychiatric Emergency Response Team (PERT)
Health Policy Organizations	The Hospital Consortium Healthcare for the Homeless and Farmworker Program	Recuperative/Respite Care Policies; strategic planning SMC Street/Field Medicine Team; Mobile Clinic/van; strategic planning

Issued: October 13, 2020

County of San Mateo

Inter-Departmental Correspondence

Department: COUNTY MANAGER
File #: 21-018

Board Meeting Date: 1/5/2021

Special Notice / Hearing: None
Vote Required: Majority

To: Honorable Board of Supervisors

From: Michael P. Callagy, County Manager

Subject: Board of Supervisors' Response to the 2019-2020 Civil Grand Jury Report "A Slow-Moving Catastrophe: Finding the Ill Homeless A Place to Heal."

RECOMMENDATION:
Approve the Board of Supervisors' response to the 2019-2020 Civil Grand Jury Report, "A Slow-Moving Catastrophe: Finding the Ill Homeless A Place to Heal."

BACKGROUND:
On October 13, 2020, the 2019-2020 San Mateo County Civil Grand Jury issued a report titled "A Slow-Moving Catastrophe: Finding the Ill Homeless A Place to Heal." The Board of Supervisors is required to submit comments on the findings and recommendations pertaining to the matters over which it has some decision-making authority within 90 days. The Board's response to the report is due to the Honorable Danny Chou no later than January 11, 2021.

DISCUSSION:
The Grand Jury made 13 findings and 11 recommendations in its report. The Board responses follow each finding and the 11 recommendations that the Grand Jury requested that the Board respond to within 90 days.

FINDINGS

> ***Finding 1:*** *There is no County department or division which coordinates the County's efforts to comprehensively address the issues faced by the homeless or ill subset. Currently, the County has at least seven departments or divisions - including HSA, the Department of Housing, SMMC, the Division of Public Health, Policy, and Planning, BHRS, and the Sheriff's Office - involved in some part of the lives of ill homeless people.*

The County ***partially disagrees*** with this finding. The County provides multiple programs for homeless residents with health issues, including street medicine, mental health support, and outreach, engagement and case management through the Homeless Outreach Teams (HOT).

While there is no one agency that coordinates the health issues for the homeless, the Human Services Agency convenes seven, city based monthly homeless outreach case management meetings for all providers of services to local homeless residents. Those meetings include health providers, and health issues are incorporated into the case management plans for clients. In addition, the Human Services Agency facilitates monthly meetings with managers from the Human Services Agency, the Department of Housing, Health, Probation, Sheriff's Office and Health Plan of San Mateo to coordinate a broad range of work related to improving the County's housing and homeless services.

> ***Finding 2:*** *City police officers with duties as Homeless Outreach Coordinators and County Sheriff's deputies who work with the Psychiatric Emergency Response Team (PERT) play a significant role in identifying the homeless, de-escalating potential conflict involving the homeless, and linking the homeless to services, including providing transportation to medical treatment entities and shelters. Some police have been trained by BHRS to work with outreach teams in the field to help deal with homeless who may be a danger to themselves or others.*

The County ***agrees*** with this finding.

> ***Finding 3:*** *Determining the financial cost to the County for treating the ill homeless is extremely difficult given the various treatment alternatives (e.g., hospitals, clinics, vans, shelters, respite care options and care delivered "on the street.") and other programs which are managed across numerous County departments and divisions. The County's Budget, Policy, and Performance unit estimated that approximately $54 million dollars was directed by the County to help ameliorate homelessness in 2019. According to the latest housing census, there were 1,512 homeless individuals in SMC.*

The County ***agrees*** with this finding.

> ***Finding 4:*** *The County invests heavily in outreach teams within and across agencies for finding the ill homeless and linking them to necessary treatment before hospitalization is required. However, it is not clearly set forth on any public website or document how these teams coordinate or interact or how their effectiveness is determined.*

The County ***agrees*** with this finding.

> ***Finding 5:*** *Of the discharge housing options available, there is a lack of appropriate shelter for individuals who are well enough to leave the hospital but still require some help to recover fully. Several County organizations, including HPSM, are funding various pilot studies for "respite" or "recuperative" care that show promise to meet this need. However, at this point, the County lacks a comprehensive plan for this service.*

The County ***partially disagrees*** with this finding. The recuperative care initiative contracted by HPSM is funded through County dollars through a partnership with County Health. Health-Public Health Whole Person Care contracts with the Health Plan who have hired a CBO, Bay Area Community Services, to operate the recuperative care site called Baden Street. Funding is Measure K funds provided to the Pilot for housing homeless clients.

The pilot appears to be meeting the need for County clients, and the County questions whether there is updated information to support that there is still a lack of this resource for homeless County clients.

There is nothing to prevent private hospitals and insurance companies from purchasing such services if their members would benefit, and the County encourages them to do so.

Recuperative care does not directly provide medical care, rather it is a safe, clean residential environment where patients can recuperate from an illness. The staff at the recuperative care site coordinate with medical providers to ensure that medical needs are met. This could include coordinating with a primary care physician as well as working to ensure that a community home health provider is able to access the patient while in recuperative care. Recuperative care is not “similar” to a licensed Board and Care (Adult Residential Facility or Residential Care Facility for the Elderly).

The recuperative care site capacity and use permit do not allow for 15 residents. At the very most the site could accommodate up to 10 persons for recuperative care.

The care navigator that works directly with the recuperative care site is part of the Public Health Bridges to Wellness team and assists with general case management needs as well as in locating and securing more permanent housing to avoid discharge to the street.

The County is implementing a plan to provide housing for all homeless residents who seek housing. That plan includes purchasing hotels, building temporary shelter space and ultimately, building a new navigation center. Respite and recuperative care beds may be included in the new facilities if data supporting such a need for County clients supports this approach beyond the Baden Street program currently operating. Details such as numbers of those types of beds will be determined as the plans for the facilities are finalized.

> ***Finding 6:*** *There is only one County shelter (Maple Street) that has a nurse on staff to provide a level of health care support for ill and recovering homeless. Grand Jury interviews revealed staff are sometimes put in the difficult position of having to decide to take or refuse some ill homeless patient due to their very precarious health status. Only Maple Street and two other single adult shelters are now open to residents 24/7 which allows the ill homeless a safe, clean environment to sleep and recover from illness.*

The County ***disagrees*** with this finding. With the onset of the pandemic the County has increased bed capacity for homeless residents by contracting with hotels. Over 70 beds have been added to the adult shelter system through the additional of hotel rooms. All shelter residents are interviewed, assessed and placed in an appropriate shelter location through the housing first single intake process managed by the eight Cores Services Agencies located throughout the County.

> ***Finding 7:*** *Most hospitals in the County, BHRS and WPC reserve (and pay for) beds at Maple Street Shelter or Samaritan House for their homeless patients requiring recuperative care. There is a lack of consistency in how to access these beds: some entities use the County’s Coordinated Entry System while others are able to by-pass this risk assessment interview. There are no data evaluating the cost effectiveness of this strategy in terms of county funding or agreement about the cost paid by different entities for these beds*.

The County ***disagrees*** with this finding. This characterization is not correct. In most cases (unless it’s after hours or on the weekend), everyone uses CES to enter a shelter. In the case when a hospital or program pays for dedicated shelter beds, that entity places using consistent hospital or program criteria into the shelter. WPC does not reserve beds at shelters at this time.

> ***Finding 8:*** *The County is in the planning stages for relocating and rebuilding the Maple Street*

Shelter. This will provide the County with an opportunity to reassess the needs of the homeless in general and the ill-homeless in particular. The ill homeless are complex, suffering from a variety of physical and mental disorders which impact their ability to access and maintain housing. Female homeless individuals and the elderly are especially at risk for future homelessness and resulting poor health.

The County ***agrees*** with this finding.

Finding 9: *Beginning in 2015, the Medicare/Medi-Cal funded "Whole Person Care Pilot" (WPC) project offered an opportunity and significant funding for SMC to develop an integrated health care plan for vulnerable individuals, including the ill homeless. As a result of WPC, the County began implementing significantly improved collaboration among partners and developing of new programs as well as expanding existing programs for treating the target populations.*

The County ***agrees*** with this finding. Much of the description of Whole Person Care is derived from the original application to the State. As with many grant applications, the actual on the ground implementation often diverges significantly from what is originally envisioned. There are a few substantive corrections that should be considered in the report:

1. WPC is a five-year pilot. 2016 calendar year was a planning year and implementation began in 2017 and originally was planned to operate through December of 2020 or 4 years. The County has recently learned from the State that they fully expect to extend the program through December 2021.
2. WPC has three target populations: seriously mentally ill (SMI), substance use disorders (SUD), and those who may experience SMI, SUD and homelessness.

Programs funded by WPC for the third target population include:

a. Bridges to Wellness - operated by PHPP is an intensive field-based case management program staffed by persons who may have a lived experience of either homelessness, SMI, SUD but who also professional experience with the population served. Some Care Navigators identify as peers, and others do not. This team also include an RN, 2 social work supervisors and a nurse practitioner. This program is not part of the Street Medicine Team, but rather collaborates closely with them as well as all other Health providers within the department. While the County originally thought the County would hold classes or groups, it became quite apparent that this population does not access these types of services well. Health education and chronic disease management are done one on one between Care Navigators and clients.

b. WPC contracts with LifeMoves to provide two community health outreach workers (CHOWS) to help us locate homeless individuals who may need to be connected to the Bridges team for more intensive care. The CHOWS do carry a small case load of homeless clients who do not require the intensive case management services provided by Bridges to Wellness.

c. The Psychiatric Emergency Response Team is not funded by WPC.

d. The WPC funded Social Workers who work within the medical center ambulatory care clinics are not mentioned here. These social workers provide substantial case management services to the ill homeless population. While this case management is not field based, it has provided a direct connection between clients, other providers and the medical staff thereby increasing greatly the coordination of care

between Health Divisions.

e. Also not mentioned here is the Integrated Medication Assisted Treatment Program (IMAT). This program began prior to WPC but has been funded and expanded with WPC dollars over the last five years. This team often works with homeless individuals who have substance use disorders. The goal is to assist patients to consider medication assisted treatment to curb cravings and achieve better control over substance use. They provide outreach to clients within the emergency department and at the sobering center. This outreach has been remarkably successful in helping clients to regain control of their lives.

Finding 10: *WPC goals related to addressing Medi-Cal churn as well as HIPAA confidentiality concerns have not yet been achieved. Furthermore, The County's WPC project lags behind other counties with regard to data sharing capabilities to support care coordination.*

The County ***partially disagrees*** with this finding. The County has undertaken to maximize allowable information sharing without jeopardizing patient privacy as required under the law. Data sharing between Health, the Department of Housing and the Human Services Agency has been a challenge due to laws that sometimes either prevent sharing or sometimes are unclear about the permissibility of data sharing. There are on-going substantial efforts to resolve some of these data sharing efforts at the local level, however success will largely depend upon leadership by the State.

Finding 11: *In order to receive and maintain Medi-Cal benefits, a home address is required. By definition, the homeless do not have one, so they substitute temporary locations such as the SMMC, shelters, or someone else's address. As a result, homeless individuals often do not receive important insurance and medical documents and become uninsured. This causes a critical gap which results in potentially insurable patients not being treated or the County health services unable to obtain reimbursement.*

The County ***disagrees*** with this finding**.** When homeless clients apply for Medi-Cal, they must provide proof of County residency and a mailing address given by a client for where they receive mail. The County does not substitute addresses.

Finding 12: *Within the County, there is a lack of affordable permanent housing of various types (e.g., Board and Care type facilities, supervised group homes, single room occupancy hotels) for the homeless with chronic or long- term conditions that require support (e.g., stable mental illness, diabetes, cancer, heart disease). Without such options, the ill homeless will likely recycle back into encampments or the streets and again rely on emergency departments for needed treatment obviating any reduction in health care savings.*

The County ***agrees*** with this finding. There is a lack of funding for affordable permanent housing of various types that has kept pace with increasing cost of housing and increasing rents. Individuals who receive an SSI payment of $1100 a month do not find that sufficient to cover rent. The County would prioritize the need for permanent housing over the need for additional medical respite resources.

Finding 13: *While the County should be applauded for reaching out to grant agencies for funding programs that support the ill homeless, it appears that such programs may not be*

sustainable after grant funding ends. Given that the County support system is already complex, the addition and subtraction of pilot programs without institutionalization provides only a finger in the dike and potentially adds to client and provider confusion about resources.

The County ***partially disagrees*** with this finding. While pilot programs do not offer permanent funding, they do test approaches to addressing complex issues and many times offer the ability to refine approaches based on lessons learned during the pilot. Pilot programs that improve client outcomes create efficiencies or improve services in other ways benefit clients and may receive ongoing funding from federal, state or local sources. WPC is one such example that has a strong likelihood of receiving continuing funding through the next new State/Federal Medi-Cal Waiver.

RECOMMENDATIONS

Regarding Pre-Hospitalization

Recommendation 1: *The County Board of Supervisors (BOS) should direct the County Manager to develop a clear outline of the departments, agencies, and community partners who receive county funds involved in assisting the homeless and the specific subset of the ill homeless focusing on points of overlap and duplication of services. The Board should also direct the County Manager to report back to the Board in a public meeting, what efforts are being undertaken to better coordinate County efforts and potentially reduce bureaucracy and costs. This report from the County Manager should be publicly presented to the Board by December 31, 2020.*

The recommendation has not yet been fully implemented. The County Center on Homelessness within the Human Services Agency coordinates all programs and services for homeless residents, working in coordination with other County departments. The priority now is the purchase, staffing and occupancy of the soon to be acquired hotels. After that work is complete and the health system is not fully consumed with the COVID-19 response, a review of the homeless system of care will be a priority.

Recommendation 2: *The BOS should direct the County's Budget, Policy, and Performance unit to annually determine the actual costs for helping the homeless and the specific subset of the ill homeless to the County by December 31, 2020.*

The recommendation has not yet been implemented. The costs of assisting the homeless will be presented to the Board of Supervisors in June 2021 as part of the Human Services Agency FY 2021-23 budget presentation.

Recommendation 3: *Because the homeless move from place to place, the BOS should request that the County Sheriff and Police Chiefs convene a task force to increase cross-jurisdictional coordination and communication. As part of this collaboration, they should determine if the number and training of officers is sufficient to address homeless outreach and crisis management in those localities where homelessness is the biggest problem. The task force should hold an initial meeting by December 31, 2020 and regularly thereafter to exchange information and best practices*.

The recommendation has not yet been implemented. The local police are key members of the seven local multi-disciplinary teams that meet monthly to review case management plans for

homeless residents. Many cities have officers dedicated to working with their homeless residents. However, there can always be better coordination and the review of homelessness services in 2021 will include working with the County Sheriff and local Police Chiefs on ways to improve program outcomes.

Regarding hospitalization, discharge options and SB1152

> ***Recommendation 4:*** *By June 30, 2021, the County's Human Services Agency (HSA) should collaborate with the Governing Board of the Health Plan of San Mateo (HPSM) to create a standard option as a housing address proxy for the homeless and ill homeless so County hospitals and services can be reimbursed for services.*

The recommendation will not be implemented. The County appreciates any effort to ensure the organization can receive appropriate reimbursement for services provided. Due to the availability of Hospital Presumptive Eligibility (which ensures that patients can be enrolled in Medi-Cal at the time of admission if certain criteria are met), however, the County does not fully understand how a housing address proxy would influence reimbursement of services. Given the logistics and cost associated with such an effort, in the absence of firm return in the form or increased reimbursement, the County would not advise pursuing this effort solely for the purpose of hospital billing.

When homeless clients apply for Medi-Cal, they must provide proof of County residency and a mailing address given by a client for where they receive mail. The County does not substitute addresses.

If one of the problems is to avoid the loss of Medi-Cal due to a lack of ability to receive mail to comply with paperwork requirements, the recommendation should be geared toward assisting clients to meet the paperwork requirements at access points that do not require mail.

> ***Recommendation 5:*** *The County should develop a comprehensive plan for medical respite/recuperative care for the ill homeless by including key representatives from appropriate County departments to collaborate with the Health Care for the Homeless and Farmworker Program and the Hospital Consortium by June 20, 2021.*

This recommendation will not be implemented. Health does currently partner with the Health Care for the Homeless and Farmworker Program and other partners regarding addressing medical respite/recuperative care needs for the homeless. The County contracts with HPSM for a 6-bed recuperative care site using local funds. This service appears to be filling most of the gap for County clients. There are no funds from health insurance or ongoing sources for this recuperative care service nor for medical respite, which would require substantial medical supervision and staffing. Generally, this level of medical supervision and staffing would not be found in a shelter site. While medical respite could meet the needs of homeless clients requiring a higher level of care post hospital stay and some instances replace the need for short term skilled nursing there is no funding for such a service, it is unclear what the demand would be and it seems unlikely it could be provided for less expense than a skilled nursing day, which at least has reimbursement under the Medi-Cal program. Private insurers and private hospitals may have resources to pursue other options, but the County is not recommending the County invest in additional medical respite/recuperative care resources at this time compared to other high priorities such as permanent housing.

> ***Recommendation 6:*** *HSA should allow the CES assessment to be more available outside of*

normal business hours and standardize its inclusion into all hospital or shelter discharge plans by October 31, 2020.

This recommendation will not be implemented due to lack of resources.

Recommendation 7: *The County should conduct an overall evaluation of the County's homeless shelters through the lens of the ill homeless, e.g., ability to assist with a range of medical needs and 24/7 availability of housing by June 30, 2021.*

This recommendation will not be implemented. Shelters are not medical facilities and are not meant to serve people with significant medical issues who may need a different level of care.

Recommendation 8: *In the planned design and rebuilding of the Maple Street Shelter, the BOS should direct the County Manager to work with departments to prioritize addressing the needs of ill homeless, especially vulnerable women and the elderly by December 31, 2020.*

This recommendation has not yet been implemented. The new Maple Street Navigation Center will include respite beds for homeless residents. When a site has been identified for that facility, which is expected to happen in spring of 2021, staff will start working on the facility design.

Recommendation 9: *The County's Department of Housing should evaluate the feasibility of securing added board and care type housing facilities to provide long-term care, staffed with appropriate medical personnel, for homeless with chronic medical and mental illness needs by December 31, 2020.*

This recommendation will not be implemented. Since the advent of the County's Affordable Housing Fund (AHF) in 2013, the County has invested over $180 million to leverage an additional $1.7 billion in affordable housing financing to create or preserve 3,300 affordable homes. Over 1,000 of those units are now complete and occupied, with roughly 700 in construction and 1,600 more in various stages of predevelopment. Most leveraged sources of affordable housing financing require local matches. Allocations of County AHF dollars allow affordable housing developers to pursue these additional financial resources to help acquire and construct permanent affordable housing in our high-cost region where construction of new units can cost over $600,000 per apartment, and acquisition of aging stock averages more than half this cost. Licensed board and care facilities and other forms of transitional housing where clients do not hold residential leases are not eligible for these leveraged affordable housing financing resources, most notably Low Income Housing Tax Credits, that allow the County's Department of Housing to produce affordable housing at this scale. Acquisition or construction of new board and care facilities would need to be done at extreme cost to the County versus the County's existing process for financing affordable housing.

Through partnership with County Health, HSA, and HPSM, DOH targets units in its AHF-financed portfolio to clients of Health and HSA. In the past five years, DOH, Health, and HPSM have moved 327 medically-frail individuals at risk of homelessness from institutional settings to permanent affordable housing and Board and Care homes with wrap-around services provided by Health and its nonprofit partners through the Community Care Settings Pilot, operated by HPSM and funded under Whole Person Care. In 2019, DOH was awarded nearly $20M in State capital funds to help finance affordable homes that will be targeted to County WPC clients. A $5 million award was made this year to Mercy Housing for its Middlefield Junction project, which will house 20 WPC clients in a 180-unit affordable housing project. The County recommends pursuing additional similar partnerships that will allow the County to create more permanent housing targeted to the County's homeless, high-need

clients.

The Department of Housing assists with the financing and development of affordable housing through the distribution of County, state and federal funds that must be used for the construction or rehabilitation of affordable housing. The Department does not own or operate board and care homes. However, board and care homes will be evaluated as an option in the plan for meeting the needs of all homeless residents of San Mateo County.

Regarding WPC

> ***Recommendation 10:*** *The County Manager's Office should work with the relevant County departments to determine if it is possible to permanently fund the integration of psychiatric personnel into all outreach efforts/teams given the high presence of mental health issues among the homeless, and should have the relevant County departments publicly report the results of this effort to the Board during a regularly scheduled Board meeting by March 31, 2021.*

This recommendation has been partially implemented. Mental Health personnel are embedded in or otherwise connected to all of the outreach teams in the County including the HOT. Some examples include the Street and Field Medicine team, which includes a psychiatrist who travels into the community 16 hours each week. The Psychiatric Emergency Response Team (PERT) embeds full-time mental health staff at the Sheriff's Office. These individuals provide mental health consultation to all officers and frequently travel into the community with a Deputy to engage individuals with mental health needs. The Family Assertive Support Team (FAST) operated by Mateo Lodge includes full time mental health staff. FAST provides services to families attempting to connect loved ones with mental health services. In addition, Mateo Lodge a field-based Mobile Support Team. Anyone in the County experiencing mental health issues can contact this team directly for assistance. This is not a crisis response team. The Assisted Outpatient Team (AOT) is staffed with mental health professionals who are available to a variety of stakeholders in the community concerned about someone who is not able to recognize their need for treatment. The San Mateo Assessment and Referral Team (SMART) closely coordinates with BHRS. SMART consists of paramedics with additional mental health training who respond to mental health situations in the community. Finally Public Health Mobile Health Van and BHRS Adult Resource Management (ARM) staff collaborate with homeless shelter personnel throughout the County providing consultation to stakeholders and individuals seeking treatment. All programs provide performance and outcome data annually.

> ***Recommendation 11:*** *The County Manager should prioritize the completion of the integrated data systems (i.e., Health Information Exchange and Enterprise Data Warehouse) which were begun under the auspices of the WPC and report back to the Board in a public meeting by December 31, 2020, whether the funding of such integration is possible and, if so, by which date it will be completed*.

This recommendation has been partially implemented. The development of the HIE and Data Warehouse has been a multi-year project funded by the Department with an infusion of funds under the WPC grant. Health currently records services within several different Electronic Health Records which have limited interoperability. The Health Information Exchange solves for this problem by pulling data from these various sources and providing it in a single view at the point of care. The HIE currently pulls from internal health records as well external health partners such Kaiser, Stanford, Zuckerberg San Francisco General Hospital and Trauma Center, and Sutter Health as well as the Health Plan of San Mateo. The County can connect to other Health Information Organizations across

the State in order to pull in data for patients who are seen outside of the local community. There have been a number of enhancements to both improve the quality of the data and expand its use including the ability to pull in pharmacy fill information, exchange information with first responders who can use the information at point of service and relay back to the emergency departments. The County has set up as part of California EMS Authority's PULSE for queries in cases of emergency such as the COVID-19 response. The Enterprise Data Warehouse pulls in data from Health's multiple E.H.R systems, matches data across the disparate E.H.R's and then allows for the development of reporting at the cohort or individual client level. Unfortunately, the County has been unable to achieve the goal of data integration with housing and social services as the County is prohibited, in many cases, by state law, and sharing information will require a State solution.

Funding for the integrated health data systems will be evaluated through the County budget development process and a report back to the Board will occur during the June budget hearings.

FISCAL IMPACT:
There is no fiscal impact associated with accepting this report.