Letter of Agreement  

Between  
Partnership HealthPlan of California and the County of Sonoma  

Recitals  

Whereas, on December 8, 2014 Partnership HealthPlan of California (PHC) issued a Request for Proposals to develop local innovation projects that would improve access to health care services throughout the PHC regions;  

Whereas, the County of Sonoma, Department of Health Services submitted the attached proposal (Attachment A) for $250,000 for medical respite services to homeless clients, providing a safe and secure shelter to recover from an acute medical condition; and  

Whereas, PHC has awarded $250,000 in Innovation Grant funds to the County of Sonoma for enactment of this proposal.  

Now, therefore, be it resolved that the County of Sonoma will provide the services described in Attachment A, starting with receipt of $125,000 in PHC grant funds and an additional $125,000 on completion of the project; and  

Be it further resolved that the County of Sonoma will provide PHC with the documentation of enactment of the proposed services as described in Attachment B as required in Attachment B and on completion of the project; and  

Be it further resolved that formalization of this Letter of Agreement shall be sufficient for PHC to issue the funds detailed above.  

Signed:  
Partnership HealthPlan of California County of Sonoma  

_________________________________   ___________________________________  

Sonoma County Department of Health Services, #2016-0xxx-A00  
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Project Summary

Project Nightingale provides post-acute medical respite care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital or Skilled Nursing Facility (SNF). The Project Nightingale Respite Care Expansion Pilot Program doubles the number of available beds for this population and will strengthen the infrastructure around the program to make it more comprehensive and sustainable.

Desired Program Outcomes

- Improved (and measured) short- and long-term health outcomes for clients.
- More appropriate use of health care services which will, in turn, lower hospital inpatient cost and decrease the number of unnecessary hospital stays and re-admission.
- Clients will be linked to a primary care home and enrolled in available enabling services to ensure that basic needs are met (especially around housing).

Project Narrative

Individuals experiencing homelessness have disproportionate rates of acute and chronic illnesses, which in turn, drives higher rates of hospital utilization. Lack of housing for this population complicates discharge planning and subsequent recovery, which can also lead to high rates of hospital re-admission\(^1\). While the Affordable Care Act (ACA) expanded Medi-Cal coverage to include low-income single adults (including most individuals who suffer from homelessness), access to insurance by itself does not necessarily reduce hospital and emergency room utilization.

Longer inpatient stays and higher emergency room utilization is a consequence of inadequate housing -- people who are experiencing homelessness have no place for rest or recuperation after treatment or hospitalization\(^2\). In order to address this need in Sonoma County, Kaiser Permanente, St. Joseph Health – Sonoma County, Sutter Medical Center of Santa Rosa and the Sonoma County Department of Health Services (DHS) have partnered with Catholic Charities of Sonoma County Department of Health Services, #2016-0xxx-A00

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the Diocese of Santa Rosa to expand and strengthen the Project Nightingale Respite Care Program in Santa Rosa.

Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital. Medical respite is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. The two most frequently cited benefits of Medical Respite Care are improvement in a homeless client’s quality of life and a reduction in hospital re-admission. Early nationwide research shows that homeless patients who participate in medical respite programs are 50% less likely to be readmitted to a hospital at three months and twelve months post-hospital discharge.

**Current Service Level**

Catholic Charities’ Project Nightingale Respite Program (Project Nightingale) provides thirteen respite beds for homeless adults who are referred when discharged from a hospital or emergency room. Clients receive access to 24/7 bed rest, three meals a day and clinical assessment, when necessary.

Currently, Project Nightingale is only able to accept clients who can manage their own medical needs (medications, wound care, medical equipment, etc.). The number of clients that have been denied service due to lack of bed space and/or high medical acuity has increased steadily and now makes up almost 60% of the program’s reasons for non-admission of referred clients.

In addition, at their present funding level, the Nightingale Program is only able to provide light referral case management. The lack of stability in the lives of individuals experiencing homelessness exacerbates existing medical conditions, and makes adherence to treatment plans more difficult. A comprehensive case management component built into a medical respite care program that promotes connections to primary and behavioral health care, links to available enabling services, and works with clients to obtain permanent housing, can also reduce hospital and emergency re-admission; thus improving efficiency and reducing long term costs to the health system.

**Proposed Use of Innovation Grant Funds**

In partnership with the three major hospitals in Santa Rosa, St. Joseph’s Home Health Care Network, and Sonoma County’s Department of Health Services, Partnership HealthPlan of California’ Innovation Grant funds will be used to support the following objectives between July 1, 2015 and July 30, 2017:

1. Expand number and admission criteria of respite care beds.
   a. A total of 26 respite beds (24/7 bed rest, 3 meals/day, onsite showering and laundering facilities, daily wellness checks); thirteen of which can be used for

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clients that qualify for home health services and who may require limited assistance with their mobility or self-care.

b. St. Joseph Home Care Network will provide acute and post-acute clinical services as determined by the client’s treatment plan on-site for those who qualify for such services.

(2) Provide Health Care Coordination – Case Manager will meet regularly with all clients in order to:

a. Support clients in meeting self-management goals;

b. Provide educational resources to client to promote knowledge about medical conditions in a manner that accommodates the client’s comprehension, including their language needs and reading levels;

c. Help client navigate health systems and establish an ongoing relationship with primary care providers/medical home;

d. Coordinate and/or provide transportation to and from medical appointment and support services;

e. Facilitate patient follow-up for medical appointments and accompanying the client to medical appointments when necessary;

f. Help clients reconcile prescriptions to a single community pharmacy and establish an ongoing relationship; and

g. Make referrals to behavioral health services.

(3) Expand Project Nightingale’s non-clinical support services

a. Comprehensive health care coordination/case management that will focus on "wrap-around" services and work with each client to link them to entitlement programs, a primary care home, behavioral health programs and more permanent housing;

b. Increased access to the Homeless Prevention and Rapid Re-Housing Program, which provides temporary and limited financial assistance (security deposit, rent or utility assistance, moving costs) for those who have lost housing or who at risk of losing housing; and

c. Provide opportunities to improve daily living skills.

(4) Create and implement a comprehensive evaluation plan, and use that data to support more sustainable, long-term funding strategies.

a. Evaluation plan will measure:

i. Client Health Outcomes

ii. Hospital Readmission Rates

iii. Emergency Department Readmission Rates

iv. Direct Service Performance Indicators (number of clients linked to primary care home, health insurance, housing, etc.)

b. In addition, return on investment will be analyzed in order to capture saving that could be reinvested in the project in the future.
Implementation/Milestone Timeline

July – October 2015: Transition from 13 respite beds to 26 respite beds
   Hire and train additional staff, including dedicated Case Manager

October 15, 2015: Higher medical acuity clients (who qualify for home health services) can now be accepted to program.


February 1, 2016 First Project Nightingale Respite Care Expansion Pilot Program progress report due – to include program activity and initial return on investment numbers by hospital.

February – June 2016 Secure remaining FY 16-17 operational funding.

June 2016 Second Progress Report due


February 15, 2017 Financial Sustainability Plan that identifies upstream cost savings, identifies potential program funders and analyzes feasibility of a capture and reinvest financial model due.

Potential Risks to Implementation

The original timeline for scaling up to full 26-bed capacity was two months; the process took longer than expected due to delays in the staff hiring process. As of October 15, 2015 all new staff was hired and higher acuity clients were being accepted. Implementation of wrap-around services and data collection, while important, will not impend the program’s ability to accept clients.

Risk: Low Utilization
Risk Level: Medium
Mitigation: Ensuring that program eligibility requirements are understood and clients are regularly referred to the program during the hospital discharge process.

Risk: Inability to secure operational funding for second year of pilot project (FY 16-17)
Risk Level: Medium
Mitigation: Multiple funders will be approached to continue program. Program will be scaled down to reach secured funding level.

Risk: St. Joseph Home Health Network can no longer offer home health services
Risk Level: Low
Mitigation: Higher acuity patients will not be accepted until alternate providers can be found.

Projected Quarterly Targets for Partnership HealthPlan of California Beneficiaries

Note: Past program data has shown that on average, clients remain onsite in the program for four weeks, although actual time in program can range from one day to over a year, depending
on client and their needs. Projections below assume the program is continually filled at 77% of its capacity and will update in each progress report.

<table>
<thead>
<tr>
<th>Period</th>
<th>Beds Available</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1 – September 30, 2015</td>
<td>13 beds</td>
<td>40 clients</td>
</tr>
<tr>
<td>October 1 – December 31, 2015</td>
<td>Transition from 13 to 26 beds</td>
<td>60 clients</td>
</tr>
<tr>
<td>January 1 – March 31, 2016</td>
<td>26 beds</td>
<td>80 clients</td>
</tr>
<tr>
<td>April 1 – June 30, 2016</td>
<td>26 beds</td>
<td>80 clients</td>
</tr>
<tr>
<td>July 1 – September 30, 2016</td>
<td>26 beds</td>
<td>80 clients</td>
</tr>
<tr>
<td>October 1 – December 31, 2016</td>
<td>26 beds</td>
<td>80 clients</td>
</tr>
<tr>
<td>January 1 – March 31, 2017</td>
<td>26 beds</td>
<td>80 clients</td>
</tr>
<tr>
<td>April 1 – June 30, 2017</td>
<td>26 beds</td>
<td>80 clients</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>26 beds</strong></td>
<td><strong>580 clients</strong></td>
</tr>
</tbody>
</table>

Sonoma County Department of Health Services, #2016-0xxx-A00
## Project Budget Summary: July 2015 – June 2017

<table>
<thead>
<tr>
<th>Provider</th>
<th>PHC Funding Request</th>
<th>Other Revenue Services</th>
<th>Sonoma County DHS In-Kind</th>
<th>Remaining Need*</th>
<th>TOTAL BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$86,471</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$127,981</td>
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<tr>
<td>Evaluation/Data Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$154,193</td>
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<tr>
<td>Home Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Subcontract for Direct Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,350,000</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$250,000</td>
<td>$1,515,000</td>
<td>$488,645</td>
<td>$465,000</td>
<td>$2,718,645</td>
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</tbody>
</table>

*Community Benefit funds will be requested from each hospital partner for remaining Year Two costs in April 2016.

### Project Budget Narrative

If awarded, funds from the Partnership HealthPlan of California’s Innovation Grant for Discharge Planning program will be used to fund the direct operational costs of the Project Nightingale Respite Care Expansion Pilot program. Currently funding for operational expenses (through a subcontract with Catholic Charities of the Diocese of Santa Rosa) will only cover costs through June 30, 2016. Without additional funds the program will not be able to remain at scale long enough to collect sufficient data on the impacts of the program on client health outcomes or effects on the hospital discharge process.
## Operational Budget Detail: July 2015 – June 2017

<table>
<thead>
<tr>
<th>Item</th>
<th>FTE</th>
<th>Hourly Rate</th>
<th>Year 1</th>
<th>Year 2</th>
<th>TOTAL BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Management – program coordination and supervision of direct services</td>
<td>.50</td>
<td>48.51</td>
<td>50,453</td>
<td>50,453</td>
<td>$100,906</td>
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<tr>
<td>Shelter Support Specialist (at Samuel L. Jones) – coordinates intake and maintains site</td>
<td>1.00</td>
<td>27.57</td>
<td>57,348</td>
<td>57,348</td>
<td>$114,696</td>
</tr>
<tr>
<td>Site Coordinator (at Brookwood) – coordinates intake and maintains site</td>
<td>1.00</td>
<td>27.57</td>
<td>57,348</td>
<td>57,348</td>
<td>$114,696</td>
</tr>
<tr>
<td>Case Manager &amp; Data Coordinator – dedicated case manager for all clients (both sites) to connect clients to benefit and entitlement services, permanent housing and behavioral health services. This position will also coordinate program data collection for evaluation purposes.</td>
<td>1.00</td>
<td>27.57</td>
<td>57,348</td>
<td>57,348</td>
<td>$114,696</td>
</tr>
<tr>
<td>Caregivers – 24-hour coverage at Brookwood site to provide aid to higher acuity clients who need limited help getting in and out of bed, using the restroom, feeding or dressing self, etc.</td>
<td>4.25</td>
<td>26.00</td>
<td>227,722</td>
<td>227,722</td>
<td>$455,444</td>
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<tr>
<td>Operational Expenses – food for meals, transportation, taxi vouchers, supplies, rent, repair/maintenance, housekeeping supplies, bedding, utilizes, IT</td>
<td>n/a</td>
<td>n/a</td>
<td>104,781</td>
<td>104,781</td>
<td>$209,562</td>
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<tr>
<td>Staff Training</td>
<td>n/a</td>
<td>n/a</td>
<td>20,000</td>
<td>20,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>Housing Financial Assistance – supplement to rent subsidies provided through the Rapid Re-Housing Program</td>
<td>n/a</td>
<td>n/a</td>
<td>100,000</td>
<td>100,000</td>
<td>$200,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$675,000</td>
<td>$675,000</td>
<td>$1,350,000</td>
</tr>
</tbody>
</table>
Attachment B

In partnership with the three major hospitals in Santa Rosa, St. Joseph’s Home Health Care Network, and Sonoma County’s Department of Health Services, Partnership HealthPlan of California’s Innovation Grant funds will be used to support the following objectives between July 1, 2016 and June 30, 2017:

**July 2016 – June 2017:** Continue expanded direct services (13 respite beds to 26 respite beds) and fully implemented home health component of care to higher medical acuity clients

**July 1, 2016:** Finalize data collection/charting methodologies, data sharing agreements and finalize comprehensive evaluation plan.

**October 15, 2016:** Project Nightingale Respite Care Expansion Pilot Program progress report due – to include program activity and initial return on investment numbers by hospital.

**January 15, 2017:** Progress Report due

**April 15, 2017:** Progress Report due

**June 30, 2017:** Prepare and present Financial Sustainability Plan that identifies upstream cost savings, identifies potential program funders and analyzes feasibility of a capture and reinvest financial model

**June 30, 2017:** Final report to Partnership HealthPlan, summarizing outcomes & ongoing funding options.
Supplemental Signature Page

Partnership HealthPlan of California
Term: Effective Date – 6/30/17
DHS Contract Number: 2016-0114-A00

Approved as to Substance:

[Signature]
Division Director or Designee

Dated 5/19/16

Approved as to Form:

[Signature]
County Counsel

Dated 5/19/16