WHOLE PERSON CARE

Mendocino County

Background

Whole Person Care (WPC) is a pilot program within Medi-Cal 2020, California's Section 1115 Medicaid Waiver. WPC is designed to improve the health of high-risk, high-utilizing patients through the coordinated delivery of physical health, behavioral health, housing support, food stability, and other critical community services.

Lead Entity: County of Mendocino Health and Human Services Agency

Estimated Total Population: 600 individuals over the pilot period

Budget: $1.8 million in annual federal funds, matched by an equal amount of local funding

Who does the program serve?

The Mendocino County WPC program annually serves up to 200 high intensity risk category individuals and up to 100 short-term care coordination risk category individuals. High intensity category individuals are Medi-Cal beneficiaries with a suspected significant mental health condition and additional factors such as frequent emergency department visits, homelessness or risk of homelessness, co-occurring substance use disorder, or recent interaction with criminal justice. Short-term care coordination is provided to individuals as they transition out of the WPC.

What health care and social service organizations are participating?

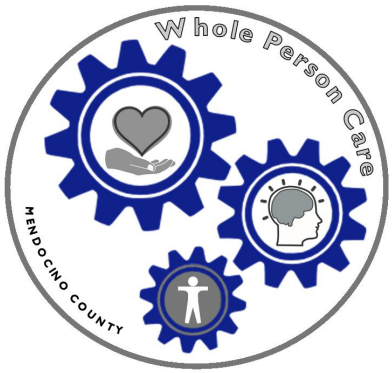
In addition to the County of Mendocino Health and Human Services Agency, four partners are involved in WPC:

- Mendocino Coast Clinics
- Mendocino Community Health Clinics, Inc.
- Redwood Quality Management Corporation
- Adventist Health – Ukiah Valley

What services are included?

The Mendocino County WPC pilot program provides enrollees with a series of care components:

- **Comprehensive Coordination of Care:** Multi-disciplinary program staff and providers conduct meetings specific to WPC enrollees, share information amongst project partners in real-time, and collect data.
- **Wellness Coaches:** Each WPC enrollee is assigned to a wellness coach that is housed at all Redwood Quality Management Corporation subcontractor sites. Coaches support participants in accessing a wide spectrum of medical, behavioral, and social services needs, including family-finding as appropriate.
- **Mental Health Resource Centers:** Mental health resource centers will be established and/or strengthened to support WPC enrollees.
- **Medical Respite:** Post-hospital medical care to WPC enrollees who are homeless, in an unstable living situation, and/or too ill or frail to recover from an illness or injury in their living usual environment are provided with medical respite services.
- **Mental Health Transitional Support:** Housing support is provided to enrollees following discharge from emergency departments or inpatient medical services, multiple inpatient psychiatric placements, and/or a conservatorship.
- **Specialized Substance Use Disorder Treatment:** WPC provides an additional substance use disorder treatment (SUDT) counselor specifically available to enrollees.



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- **Connections Coordinator:** Housing coordination, family-finding, community integration, and tenancy care services are additional services provided to WPC enrollees

A WPC enrollee may expect:

- A wellness coach to serve as the single point-of-contact and navigator for their holistic care
- Access to short-term housing following discharge from the emergency department, psychiatric inpatient hospitalization, and/or conservatorship
- Access to short-term supportive housing, following discharge from the hospital for a complex medical procedure and/or surgery
- Expedited access to substance use disorder treatment
- Direct access to navigation and support for primary health care needs at their local community health center

How are participants enrolled?

Participants are enrolled through a screening process that accepts referrals from primary health care providers, behavioral health care providers, and local hospitals. Referrals are screened for eligibility before the enrollee is contacted for participation.

How is data being shared?

Adult multi-disciplinary teams have been established to coordinate the collection and sharing of data. Grant deliverable data and relevant enrollee data, includes blood glucose levels, housing status, substance use disorders, and emergency department visits and hospitalizations. The data is prepared in a format that all project partners can understand and integrate into their workflows. A simple, streamlined, shared data infrastructure primarily focused on outcomes for clients is under development and will facilitate comprehensive data sharing amongst all partner entities.

"Our Whole Person Care project draws on our strength as a rural community. Our collaborative partners have a long history of working together toward mutual goals. Through this project, we are using these trusting professional relationships to build a seamlessly integrated system for the benefit of some of the most vulnerable members of our community."

— Anne C. Molgaard, Director
Mendocino County Health and Human Services Agency