WHOLE PERSON CARE

Placer 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: Placer County Health and Human Services

Estimated Total Population: 450 clients served over pilot period

Budget: $2 million in annual federal funds, matched by an equal amount of local funding

Who does the program serve?

The Placer County WPC pilot target population includes individuals who are eligible for Medi-Cal and have: 1) a history of repeated incidents of avoidable emergency department use and hospital readmissions; 2) two or more chronic health conditions; 3) a mental health diagnosis and/or substance use disorder; 4) currently homeless or at risk of homelessness; and/or 5) scheduled for release from jail and who meet the WPC target population criteria.

What health care and social service organizations are participating?

A total of 20 entities, including health and social service organizations, are participating:

- Placer County Health and Human Services Department
- Anthem Blue Cross
- California Health and Wellness
- Placer County Housing Authority
- Placer County Probation Department
- Sutter Roseville Medical Center
- Sutter Auburn Faith Hospital
- WellSpace Health
- Western Sierra Medical Center
- Chapa-De Indian Health
- Advocates for Mentally Ill Housing, Inc. (AMIH)
- Community Recovery Resources (CoRR)
- Turning Point Community Programs (Turning Point)
- Pacific Education Services (PES)
- The Gathering Inn
- Volunteers of America (VOA)
- Homeless Resource Council of the Sierras (HRCS)
- Sierra Foothills AIDS Foundation
- Sierra Mental Wellness Group
- Placer Independent Resource Services (PIRS)

COUNTY OF Placer WHOLE PERSON CARE

WHOLE PERSON CARE

Placer County

What services are included?

The WPC pilot is focused on four core services: 1) engagement; 2) comprehensive complex care coordination; 3) medical respite care; and 4) housing services.

- Engagement services consist of outreach and enrollment activities, care coordination, motivational interviewing, and wellness and recovery encouragement.
- Comprehensive complex care coordination provides enrollees with ongoing case management and support services, comprehensive health and social needs assessments, care linkage, and peer advocacy services.
- The Medical Respite program consists of a five-bed home-like facility for individuals who may be frequently hospitalized for two or more conditions; have frequent emergency department visits for routine health conditions; and/or need help in managing their chronic health conditions. The program provides post-hospital medical care to enrollees who are homeless, in an unstable living arrangement, and/or too ill or frail to recover from an illness or injury in their usual living environment. Enrollees receive core services, including referral and linkage, treatment planning, case management, transportation, medication support and reconciliation, nursing care, and linkage to other health and social services.
- Housing services consists of a housing assessment, development of an individualized housing support plan, housing application assistance, and identifying and securing resources to cover rent, moving expenses, and housing goods costs.

How are participants enrolled?

The WPC pilot utilizes an engagement team consisting of a nurse, peer advocates, a clinician, and a probation officer to visit shelters, homeless camps, and other known areas where target population individuals live in the community. The engagement team works with individuals to build trust, identify and establish wellness and recovery goals, and motivate individuals to enroll in the WPC program. Individuals may also be referred to the WPC program by hospitals, emergency departments, and/or primary care clinics.

How is data being shared?

The WPC pilot is funding the capacity to develop and expand a data sharing system that will identify individuals who are current WPC members or who meet criteria for WPC referral. The pilot has already implemented the "PreManage" system, which updates care coordination team members in real time when a WPC member is admitted, discharged, or transferred from an area hospital. The PreManage system also facilitates sharing of treatment plans and other care coordination documents across various sectors. As the pilot is implemented, additional data-sharing tools will be developed and personnel will be trained in the necessary systems.

"If a client needs to get to a physical therapy appointment, we're there. If they need to fill out an application for an apartment, we're there. If they need someone to help clean up a résumé, we're there. They know someone is in their corner – and that relationship has a profound impact on their success."

— Geoff Smith, WPC Program Manager
Placer County Health and Human Services