

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.

Who does the program serve?

The WPC program, called Pathways, targets Sacramento's most vulnerable individuals, enrolled in or eligible for Medi-Cal, who are homeless or at-risk of homelessness. The program supports individuals with the highest service needs, and highest utilization and costs associated with ambulance rides, fire and police department encounters, health emergencies, and hospitalizations.

What health care and social service organizations are participating?

- **Government:** City of Sacramento, including Sacramento Police Department and Sacramento Fire Department, and Sacramento Housing and Redevelopment Agency
- **Primary Care and Behavioral Health:** River City Medical Group, Elica Health Centers, HALO, One Community Health, Peach Tree Health, Sacramento Native American Health Center, TLCS, Turning Point, and WellSpace Health
- **Health Plans:** Access Dental, Aetna, Anthem Blue Cross, Health Net, Kaiser Permanente, Liberty Dental, Molina Healthcare, and United HealthCare
- **Hospitals:** Dignity Health, Kaiser Permanente, Sutter Health, and UC Davis Health
- **Community-Based Organizations/Homeless/Housing/Social Services Providers:** 211 Sacramento, Capitol Health Network, Community Against Sexual Harm, Lutheran Social Services, Sacramento Covered, Sacramento Steps Forward, Sacramento Self-Help Housing, Salvation Army, and VOA

Lead Entity: City of Sacramento

Estimated Total Population: Pathways will serve a minimum of 3,250 individuals from 2017-2020. At full capacity, the program will have 1,000 individuals enrolled and receiving services on any given day

Budget: \$6.4 million in annual federal funds, matched by an equal amount of local funding

What services are included?

Pathways provides services in four main areas:

1. Assertive Community Outreach:

- Assertive outreach and engagement of potential clients in the field
- Warm handoff to enrollment and eligibility provider for program enrollment, assessment of health, behavioral health, housing, social services needs, and acuity level
- Development of participant profile that identifies key needs, including the individual's self-identified priorities and goals
- Ongoing coordination and support for client's day-to-day needs and psychosocial support throughout program enrollment

2. Enrollment and Eligibility:

- Medi-Cal eligibility determination and enrollment
- Identification and/or assignment of client's health plan and primary care provider
- Enrollment of clients in housing and other benefits
- Identification of clients' enrollment in other case management programs
- Determination of clients' eligibility for Pathways and program enrollment

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HEALTH + HOME

- Collaboration with outreach workers on development of participant profile, including acuity-level assignment and clinical sign-off
- Assignment and warm handoff of client to Pathways care team based on health plan and primary care provider (PCP) assignment, acuity level, geography, etc.

3. Comprehensive Care Planning & Connection to Integrated Health and Housing Supports:

Interdisciplinary Pathways Care Teams serve as the “Health Home” for the client using a centralized care management platform to facilitate co-management of participants and providing the following services:

- Development and real-time updating of the shared care plan
- Navigation of and expedited access to health, behavioral health, and social services
- Housing supports and services, including transportation, apartment search, application support, landlord relationship management, and deposit and housing setup support
- “Whatever It Takes” complex care management services, care coordination, and follow-up across organizations and service systems

4. Expanded Intensive Respite Care Services for Homeless Individuals Exiting Hospitals:

- 16 additional beds for post-acute 24-hour residential respite care program
- Services including nursing, monitoring of medication management, and oversight during recuperation

How are participants enrolled?

Assertive outreach workers collaborate closely with referral partners. For example police, fire, hospitals, and clinics, help identify individuals who are potentially eligible for the program. The outreach workers make persistent and consistent contact with individuals in the field, establishing relationships, building trust, and engaging individuals to enroll in the program. Outreach workers also provide warm handoffs and collaborate with the eligibility and enrollment provider to ensure timely enrollment in the program, assessment of service needs and acuity, and assignment to a Pathways Care Team to receive more comprehensive health and housing supports.

How is data being shared?

Pathways data sharing is supported by partner execution of data sharing agreements and Business Associate Agreements. The data is currently being shared through the use of standardized data collection templates and protocols until collection is automated. The program is in the process of developing a centralized care management platform that will allow partner organizations to share data on enrollees in real-time.