WHOLE PERSON CARE

San Diego 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.

Who does the program serve?

The San Diego County WPC pilot, called Live Well San Diego, serves Medi-Cal patients who are high-cost, frequent users of emergency departments and/or inpatient hospital services. These patients also are experiencing homelessness or are at risk of homelessness and have one or more of the following conditions: serious mental illness, substance use disorder, and/or a chronic physical health condition.

What health care and social service organizations are participating?

A total of 13 entities, including health and social service organizations, are participating:

- 11 San Diego/Community Information Exchanges
- County of San Diego Health and Human Services Agency (HHSA)
- Legal Aid Society/Center for Consumer Health Education and Advocacy
- Public Safety Group (Probation and Sheriff's Department)
- San Diego Health Connect
- San Diego Housing Commission
- Aetna Healthcare
- Care 1st
- Community Health Group
- Health Net
- Kaiser Permanente
- Molina Healthcare
- United Healthcare

Lead Entity: County of San Diego, Health and Human Services Agency (HHSA)

Estimated Total Population: 1,049 clients served over pilot period

Budget: $4.3 million in annual federal funds, matched by an equal amount of local funding

What services are included?

WPC clients will be supported by Service Integration Teams (SITs). The SITs are comprised of a social worker and peer support specialist that are supported by a licensed mental health clinician, housing navigator, and registered nurse. The SITs help coordinate, communicate, and advocate the WPC client's care and goals. WPC clients establish a Comprehensive Care Plan (CCP) that includes nine items: physical health, housing, mental health, substance use, income, legal issues, support system, transportation, and quality of life. The SITs will integrate care coordination, including connecting with housing resources, transition services and tenancy sustaining services. They also utilize existing resources, including Medi-Cal Managed Care Plans, community clinics, County of San Diego HHSA Behavioral Health Services, and Veteran Services (if eligible), for better health outcomes and quality of life.

SITs will conduct outreach and engage identified eligible clients using motivational interviewing and trauma informed care practices. Once clients are enrolled, the "stabilization phase" begins with the development of the CCP and finding housing. Once clients have stable housing and are fully engaged in their CCP, requiring minimal SIT support, they are promoted to the "maintenance phase." After this, clients enter the "transition" phase where they develop a strong support system, stabilized housing, substance abuse recovery, regular income, and demonstrate improvements in physical and behavioral health. Clients are offered up to 12 months of "after care" in the final phase, demonstrating their ability to function independently, with a strong, ongoing support system, consulting the SIT as needed.

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How are participants enrolled?

WPC SITs use target population and eligibility data provided by the clinical review team, and assistance from a network of community outreach workers, to identify potential participants. SITs use best practice models, including assertive street outreach, motivational interviewing, and stage of change approach, to build relationships with clients and identify and overcome barriers to accepting services. The majority of clients enroll in the pilot within three months of intensive outreach.

How is data being shared?

San Diego County currently has a robust data infrastructure, including ConnectWellSD, Community Information Exchange (CIE), San Diego Health Connect (SDHC), Homeless Management Information Systems (HMIS), and the managed care plans (MCP) databases. While data infrastructure to conduct outcome tracking and reporting will use existing systems, it is expected that ConnectWellSD, HIE, CIE, HMIS, and MCP databases will be linked electronically for more robust reporting and enhanced care coordination over the course of the pilot.

"San Diego's Live Well San Diego framework envisions a region where every resident is healthy, safe, and thriving. Our Whole Person Wellness pilot will help our community's most vulnerable residents navigate systems and services to so they can achieve their goals and further our region to a place where we are all living well."

— Nick Macchione, FACHE
Agency Director
Health and Human Services Agency