WHOLE PERSON CARE

San Mateo 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: San Mateo County Health System

Estimated Total Population: 5,000 clients served over pilot period

Budget: $16.5 million in annual federal funds, matched by an equal amount of local funding provided by San Mateo County Health System

Who does the pilot serve?

San Mateo County's WPC pilot aims to improve the lives of individuals who have had four or more visits to the emergency department in the prior year, and who fall into one of three target populations:

A. Serious mental illness and/or medical conditions and barriers to community living that result in avoidable or extended stays in locked facilities or residential care

B. Substance use disorder interferes with ability to manage healthcare and receive other treatment needs

C. Homeless or recently discharged from jail with a serious mental illness and/or substance abuse disorder

What health care and social service organizations are participating?

Sixteen partner organizations are participating in San Mateo County's WPC project, including:

- **San Mateo County Health System divisions include:** San Mateo Medical Center and Clinics (SMMC), Behavioral Health and Recovery Services (BHRS), Correctional Health (CHS), Public Health Policy and Planning (PHPP) and Aging and Adult Services (AAS)
- **Key county department partners include:** San Mateo County Housing Department and Housing Authority, the public housing authority; and San Mateo County Human Services Agency (HSA), the county agency responsible for all human services in addition to homeless outreach, shelter, and other housing supports
- **The Health Plan of San Mateo:** San Mateo County's single Medi-Cal managed care health plan

Community partners include:

- **Stanford University Medical Center ED & Clinics:** Operates ED and Trauma Center that serves WPC enrollees
- **Brilliant Corners:** Provides housing and supportive services to Whole Person Care enrollees
- **Institute on Aging:** Provides services to aging adults and people with disabilities transitioning from skilled nursing facilities to the community
- **LifeMoves:** Operates shelter and housing locator services and Homeless Outreach Team
- **StarVista:** Operates First Chance Sobering Center
- **Horizon Services:** Operates a detox center
- **HealthRIGHT 360:** Provides Integrated Medication Assisted Treatment for substance abuse
- **Heart and Soul:** Provides peer support to those with mental illness to support recovery
- **Voices of Recovery:** Provides peer support to those with substance use disorders to support recovery
- **NAMI San Mateo:** Provides parent partners to support to family members

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How are participants enrolled?

Individuals eligible for WPC are identified through various sources, including primary care providers, BHRS clinicians and case managers, emergency department staff, and social service programs. Care navigators may also engage and enroll patients in courts, detox centers, mobile health clinics, and the pain clinic. Referrals are sent to a centralized triage nurse who determines eligibility and recommends the best program for WPC enrollees.

What services are included?

The WPC pilot leverages existing successful initiatives to coordinate care, giving enrollees access to integrated physical and behavioral health care provided by existing county services and other key partners, linkage to appropriate social supports, peer support and mentoring, and additional services provided based on needs.

Enrollees in target population A, who have a serious mental illness and/or other complicated medical conditions, have their care coordinated by the Community Care Settings Pilot (CCSP). CSSP, a 2014 initiative with similar goals to WPC initiative, is designed to prevent institutionalization and uses a multi-disciplinary Collaborative Care Team (CCT) to assist those in locked facilities in returning to the community. In addition to care coordination, these enrollees receive care navigation through the Bridges to Wellness Team, peer support and mentoring, transportation assistance, and housing supports.

Enrollees in target population B, who have a substance use disorder, have their care coordinated by the Integrated Medication Assisted Treatment Team (IMAT), an outreach and intensive case management model to support those with substance use disorders. These enrollees have access to a sobering center, residential detoxification services, treatments for opioid use, and pain management education and programming.

Enrollees in target population C, who are homeless or were recently released from jail, have their care coordinated by the Bridges to Wellness Team (BWT), which utilizes a multi-disciplinary care navigation model and leverages field based street medicine and a mobile health clinic. This target population also benefits from a re-entry program focused on those who cycling in and out of jail. These enrollees receive more intensive care coordination and housing support services, including care packages with living supplies (blankets, hygiene, food), self-management and empowerment education, and transportation assistance.

How is data being shared?

San Mateo's WPC pilot is utilizing an integrated and secure health information exchange to serve all target populations, with direct secure messaging and encrypted communications between providers. Predictive analytic tools identify patients who are likely to become high users of the emergency systems, which allow providers to intervene earlier.

A health system-wide single consent form has been vetted and will streamline dozens of consent forms. The WPC pilot has created a single comprehensive care plan model to be used throughout the health system.

"We already have the structures in place to provide the level of care and support that these patients need. The key for us is getting all these entities to communicate with each other and all move together in the right direction for each patient."

— Peter Shih, Senior Manager of Delivery System Planning
San Mateo County Health System