WHOLE PERSON CARE

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Going Beyond Medical Services to Help Vulnerable Californians Lead Healthy Lives

CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

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"Whole Person Care is providing an opportunity for the most vulnerable in our system to have an integrated care experience that collaborates to provide medical care, behavioral health care and social service needs into a systematic delivery model. In addition to the improvements in care, it is requiring the system to break down barriers and join into partnerships for an unprecedented system integration."

— Pam Rogers-Wyman
Director of Adult Behavioral Health Services, Santa Cruz County

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CALIFORNIA'S WHOLE PERSON CARE (WPC) PILOT PROGRAM:

Many factors impact health. For people in low-income communities, medical problems can be caused and exacerbated by factors related to poverty—also referred to as social determinants of health—including poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity.

Geographic Distribution and Size of WPC Pilots

Please note profiles available on 22 of 25 WPC pilots

While services may be available to help alleviate some of these stresses and inequities, they can often be delivered in a siloed fashion, where different types of service providers do not regularly communicate or coordinate care, even though they may be serving the same individuals and families.

Appreciating the importance of social determinants of health, California's healthcare and social needs providers are increasingly working together to take a "whole person" approach that extends far beyond traditional health care services.

Going Beyond Medical Services to Help Vulnerable Californians Lead Healthy Lives

Whole Person Care Pilots

California's current five year Section 1115 Medicaid waiver (known as Medi-Cal 2020) includes a $3 billion pilot program to improve care for a subset of complex Medi-Cal beneficiaries by supporting local efforts that embrace the Whole Person Care (WPC) philosophy.

Through a competitive process, the California's Department of Health Care Services (DHCS) selected 25 WPC pilots to participate in the program. Each pilot is tailored to the local context and needs of the population it serves. Health care and behavioral health providers, social services, and community partners, such as housing support organizations, work together to identify their highest-need clients and provide them with comprehensive, coordinate care.

Looking Ahead

Over the next three years, WPC pilots will identify and test new ways to bridge the silos in California's safety net system, with the potential to spread best practices to improve health throughout the state and country. The California Association of Public Hospitals and Health Systems, the California Health Care Safety Net Institute, the County Health Executives Association of California, and the California State Association of Counties have collected information on the various WPC pilots to illustrate the state's effort to improve the health of the most vulnerable. Individually, each profile can be used to underscore the health care innovation occurring locally.

Learn more at caph.org/wpc.

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?

Alameda County's WPC pilot, Care Connect or AC Care Connect, targets individuals with complex conditions who are receiving care management in one system, but require care coordination that crosses multiple systems. Many of these individuals are high utilizers of costly services and many are homeless or at risk of becoming homeless.

What health care and social service organizations are participating?

Twenty-one partner organizations are participating in AC Care Connect including:

- **Alameda Alliance for Health:** Medi-Cal managed care organization
- **Alameda Behavioral Health Care Services:** Managed care provider for seriously mentally ill patients, and the lead agency for county's substance use treatment services
- **Alameda County Probation Department:** Works with justice-involved individuals
- **Alameda Health System:** County public health care system
- **Anthem BlueCross:** Medi-Cal managed care organization
- **Community Health Center Network:** FQHC association with 42 sites
- **East Oakland Community Project:** Operates the County's largest homeless shelter
- **EveryOne Home:** housing services organization

Other partners include city and county-level public agencies, community organizations, and health care providers.

Lead Entity: Alameda County Health Care Services Agency

Estimated Total Population: 20,000 over the course of the 5-year pilot, including an estimated 10,000 homeless

Budget: $28.4 million in annual federal funds, matched by an equal amount of local funding provided by Alameda County Health Care Services Agency

What services are included?

AC Care Connect's core care management services bundle focuses on two groups – patients who are homeless or facing homelessness, and patients with more stable housing.

Both tiers include enhanced linkage to substance use disorder treatment, crisis stabilization services, and increased access to social services, as well as specialized assistance in both getting access to and navigating the county's existing physical and behavioral health delivery system. AC Care Connect also includes staffing support for behavioral health services.

About half of AC Care Connect's funding is allocated to provide housing support for approximately 10,000 of the program's enrollees. AC Care Connect implements eight distinct housing interventions:

- **Enhanced Housing Transition Service Bundle** for patients who require a high level of support to navigate into housing
- **Housing and Tenancy Sustaining Service Bundle** to support services including household management, landlord relations coaching, and dispute resolution

alameda county care connect

- **Skilled Nursing Facility Housing Transitions Program** for patients who do not meet the medical necessity requirement for supportive housing but lack the resources to transition to independent community settings
- **Street Outreach** includes a one-time investment in building relationships with unsheltered chronically homeless individuals and linking them to care
- **Community Living Facilities Quality Improvement** to help residential hotels and care facilities, which are not regulated by the government, provide clean and safe housing for low-income persons
- **Housing Education and Legal Assistance Program** to assist low-income and high-utilizing populations with housing access or retention problems in maintaining their housing
- **Flexible Funding Pools** to help participants with moving expenses using a client move-in fund, as well as a landlord recruitment and incentive fund, to encourage more landlords to offer units to low-income subsidy holders
- **Housing Development Pool** to support the construction of new permanent supportive housing units. These loans are part of AC Care Connect, but do not use WPC funds

How are participants enrolled?

AC Care Connect uses merged data from multiple sources to identify individuals eligible for the program and drive outreach efforts. AC Care Connect also flags crisis entry points, where a person eligible for the program would be likely to receive services. These include hospitals/ERs, jail, housing/homeless support, specialty mental health, EMS, and substance abuse treatment.

When patients register at a crisis entry point, AC Care Connect staff determine whether they are already in the AC Care Connect system, and if not, whether they are eligible and should be contacted by a care manager. A new data system is being built, which will allow patients to be automatically identified as WPC eligible at the point of entry.

How is data being shared?

Alameda County's WPC pilot includes the creation and implementation of a new shared data system to ensure that service providers have access to the information they need to coordinate and provide the appropriate care, while also protecting patient privacy and adhering to data sharing regulations. Many of these concerns are addressed by making behavioral health care services the repository of the data. The system is planned to go live in year three of WPC. Until then, low-tech/high-security measures are being used to share data for enrollees.

"The work we've done in breaking down silos across sectors is unprecedented, and launching this program has opened up new and exciting lines of communication with our partners. Strengthening these relationships will benefit all those we serve in our county."

— Kathleen A. Clanon
Medical Director Health Care System Planning & Improvement
Alameda County Health Care Services Agency

Background

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Who does the program serve?

Contra Costa County's WPC pilot, called CommunityConnect, serves the county's highest utilizers across all health care sectors. These patients are identified through a predictive risk model that incorporates data from multiple county systems, including data from health care, homeless, mental health, substance use, housing and detention services.

What health care and social service organizations are participating?

Partner organizations participating in Contra Costa County's WPC pilot include:

- **Bay Area Legal Aid:** Bay Area Legal Aid will provide legal support to the WPC population with housing, disability and any other legal issues that arise
- **Contra Costa Health Plan:** Medi-Cal managed care plan
- **Contra Costa Health Services**

  Contra Costa County Department of Public Health: This department promotes and protects the health and well-being of the individual, family and community in Contra Costa County

  Contra Costa County Emergency Medical Services: The EMS department will benefit from the shared data proposed in the CommunityConnect Program

  Contra Costa Regional Medical Center and Health Centers: A full service county hospital and offers a complete array of patient-centered health care services for WPC participants

Lead Entity: Contra Costa Health Services

Total Population: 52,500 over the course of the 5-year pilot

Budget: $20.4 million in annual federal funds, matched by an equal amount of local funding provided by Contra Costa Health Services

- **Contra Costa Health Services, Behavioral Health:** The Behavioral Health Department is committed to the CommunityConnect Program and has been an active collaborator throughout this pilot program
- **Contra Costa Employment Human Services Division:** This public benefits administration provides child and family services to Contra Costa residents
- **La Clinica De La Raza:** La Clinica provides outreach, engagement, care coordination support, data sharing, and participation in the governing board
- **LifeLong Medical Care:** LifeLong Medical Care will provide outreach, engagement, care coordination support, data sharing, and participation in the governing board
- **Kaiser Permanente:** Kaiser Permanente participates in the Program's governing board and data sharing efforts and provides administrative support to the program
- **Health Leads:** A non-profit organization that provides data support and sharing, tools for care coordination, and participation in the governing board
- **Re-entry Success Center:** The Center will provide social support, engagement, links to care coordination, data sharing and participation in the governing board

What services are included?

CommunityConnect's enhanced and coordinated case management model provides medical, behavioral health, and social services including housing stability, assistance with assessing public benefits (SNAP, SSI, GA) and integrated care coordination. Social resources are provided to patients in addition to transportation, legal and money management services.

Upon enrollment and based on need, patients are assigned to one of two groups for case management:

- **Group A –** Intensive Case Management: Patients who have complex medical and behavioral health needs are managed by interdisciplinary teams and provided long-term intensive and comprehensive case management services that are primarily field-based.
- **Group B** – Social Case Management: Patients in Group B also have complex medical and behavioral health needs; however, the drivers for inappropriate system utilization may appear to be more social in nature as presented in initial data reviews. Case management services provided to Group B patients include social resources including skills coaching and money management. Patients are managed in a primarily telephonic environment by interdisciplinary teams.

How are participants enrolled?

CommunityConnect identifies eligible patients by utilizing a predictive risk model to identify high utilizers through data from the electronic health record, payment claims, and other data housed in our system-wide data warehouse. An intake process is completed to assign the patient to the appropriate interdisciplinary team and case manager. The assigned case manager engages and confirms interest in program participation. If a patient is interested in participating, the case manager performs additional screening, obtains necessary consents, and reviews the patient's data and service history to determine and apply the appropriate tier of case management.

How is data being shared?

CommunityConnect is housed within the integrated data system shared by the Contra Costa Health Plan, Contra Costa Regional Medical Center and Clinics, Detention Health, Department of Behavioral Health and Emergency Medical Services. Using WPC funds, the County has increased the number of clinics and specialties utilizing the shared electronic health record. Other enhancements include new software to integrate directly with community emergency departments, housing providers, expanded population health management tools, and increased screenings of and resources to address the social determinants of health.

"After screening more than 6,000 patients over a two-year period at one of our FQHCs, we consistently found that over half identified food security as a need they wanted help with. Helping patients address conditions like these will improve their lives, and empower them to better manage their physical health conditions."

— Sue Crosby
Public Health Nursing Director
Contra Costa Health Services

Background

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Who does the program serve?

The Kern County WPC pilot targets the needs of high utilizers of emergency and inpatient services with two or more chronic conditions, with an emphasis on those who are homeless or at risk of becoming homeless and those recently released from jail.

What health care and social service organizations are participating?

Fourteen partner organizations are participating in Kern County's WPC pilot project including:

- **Community Connection for Child Care (CCCC):** Provider of child care and development
- **Golden Empire Gleaners:** Local food bank
- **Health Net Community Solutions:** Medi-Cal managed care plan

Lead Entity: Kern Medical

Estimated Total Population: 2,000 individuals over the pilot period

Budget: $15.7 million in annual federal funds, matched by an equal amount of local funding provided by Kern Medical

- **Housing Authority of Kern County (HA):** County housing authority and provider of affordable housing in Kern County
- **Kern County Aging & Adult Services (AAS):** County advocate for older adults and disabled individuals
- **Kern County Department of Human Services:** County safety net program provider
- **Kern County Employers' Training Resource (ETR):** County workforce training provider
- **Kern County Homeless Collaborative:** Community-based organization with a network of nonprofit service providers
- **Kern County Mental Health (KCMH):** County mental health provider
- **Kern County Probation:** County probation department
- **Kern County Public Health (KCPH):** County public health organization
- **Kern County Sherriff's Office:** County detention facility provider
- **Kern Health Systems:** Medi-Cal managed care plan
- **Kern Medical:** County public health care system and lead entity

What services are included?

WPC enrollees in Kern County receive a standard set of services provided by Kern Medical, including intensive care coordination and personalized care plans, wellness/lifestyle education and health coaching, regular mental health screenings, access to telephone visits, and medication management. Those who are experiencing or at risk of homelessness also have access to additional services, such as tenant screenings and housing assessments, assistance with the application process, and help resolving disputes with landlords or neighbors. A different set of additional services is available to enrollees returning to the community post-incarceration, including an enhanced level of care coordination for the first 90 days, support identifying and applying for assistance programs, and life skills transition classes geared towards reducing recidivism.

How are participants enrolled?

WPC utilizes two different methods of enrolling patients. For patients who are being released from jail, potential enrollees receive an immediate wellness check at an on-site clinic established at the jail facility. Enrollment specialists collaborate with the Sherriff's office to identify potential enrollees for WPC and assist with Medi-Cal paperwork.

For all other clients, enrollment specialists receive referrals from Medi-Cal managed care plans for beneficiaries with two or more chronic conditions, and perform outreach to arrange appointments with the WPC Patient-Centered Medical Home (WPC PCMH).

How is data being shared?

Kern County is deploying a software platform that collects and houses electronic medical record data, as well as data related to social determinants of health (such as education level, employment status, and social services support needs). The platform allows for bi-directional data sharing across partnering organizations, as well as data analytics capabilities, allowing partners to meet all the needs of their patients.

"Whole Person Care gives us the chance to change the lives of the individuals we see in our inpatient beds and emergency rooms over and over, by walking them through personalized care plans, giving them the help they need to learn about and manage their conditions, and linking them to services that can give them the life skills and social supports they need to stay healthy."

— Tyler Whitezell
Vice President, Administrative Services
Kern Medical

Background

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Lead Entity: Kings County

Estimated Total Population: 600 individuals over pilot period

Budget: $1.2 million in annual federal funds, matched by an equal amount of local funding

Who does the program serve?

The target population of Kings County WPC pilot, called KARELink, consists of Medi-Cal (MC) Beneficiaries living in Kings County that have one or more of the following: Substance Use Disorder (SUD), Mental Health Issue (MH), poor control of diabetes, and/or hypertension.

What health care and social service organizations are participating?

There is a total of nine organizations participating in the pilot:

- Kings County Human Services Agency (Lead Entity)
- Kings County Behavioral Health
- Kings County Public Health
- Kings County Probation
- Kings County Sheriff
- Champions Recovery Alternative Programs
- Anthem Blue Cross Managed Care
- Adventist Health
- Kings View Mental Health Services

What services are included?

- **Referrals** – No wrong door approach for referrals into the program. Referrals will be taken via manual forms, web portal (www.KARELink.org), phone, fax, email, or as a walk in. Various organizations throughout the community have been informed of how and who to refer into the program.
- **Screenings** – All referrals are screened by a Multi-Disciplinary Team (MDT) for the following: eligibility for any/all public assistance, SUD/MH, physical health, housing stability, and job navigation. Each member of the team develops recommendations for the case management team based on the needs/goals of the enrollees as well as the professional insights from the MDT.
- **Case Management/Care Coordination & all other services** MDT's as well as invested coordinating service providers (e.g. probation officers, social workers, mental health case managers) meet to finalize and review the enrollee's needs, goals, and recommendations from the MDT. Case managers from all service providers have a clear understanding of what each role they will play in the case management. Services available include housing stability, job navigation, best practices for SUD/MH and physical health as well as access to sobering beds, tattoo removal for job seekers, SSI advocacy, and life skill classes.

"I like coming here. I feel like the staff listen to me. I have referred some of my friends to KARELink."
— KARELink enrollee

How are participants enrolled?

Clients are enrolled after a screening process by the MDT, specifically after the eligibility, physical health, and SUD/MH screenings.

How is data being shared?

At present, data is being shared in two ways. Those actively working with enrollees have access to a shared drive on the County server where providers have access to client data at all times. Participating entities and coordinated services providers that do not have access recieve information via encrypted emails. Efforts to Outcomes (ETO) Social Solutions has been purchased for data sharing and bi-directional data. ETO will provide automated and customizable reports for further analysis of collected data, expand data sharing between participating entities, and uniform communication methods between the various entities.

"For years, we referred our clients to programs and services to simply fulfill the terms and conditions ordered by the Court. In recent years, our focus has shifted toward making more nuanced risk and needs assessments of our clients; however, the enhanced services we required were lacking. With the addition of KARElink as a partner in Kings County, service delivery to justice involved individuals has improved significantly. Individuals are able to receive services for substance use, behavioral health, health and other critical social service needs in one stop. This coordination of efforts has increased the efficiency of our system and we believe it will greatly improve outcomes for our clientele."

— Dan Luttrell
Deputy Chief Probation Officer

WHOLE PERSON CARE

Los Angeles 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 coordinated delivery of physical and behavioral health services, housing support, food stability, and other critical community services.

Who does the program serve?

The Los Angeles County WPC program, called Whole Person Care – Los Angeles (WPC-LA), seeks to ensure that the most vulnerable Medi-Cal beneficiaries have the resources and support they need to thrive. WPC-LA brings together health and social service delivery entities across the county and employs a variety of cross-cutting strategies to provide care coordination services to Medi-Cal beneficiaries. The pilot encompasses sixteen different programs to serve individuals in six high-risk populations:

- **Homeless High-Risk:** Individuals experiencing homelessness who have multiple contacts with the health delivery system, and/or disability, or chronic physical or behavioral health conditions.
- **Justice-Involved High-Risk:** Individuals returning to the community from the justice system who have multiple and/or complex chronic physical or behavioral health conditions and a high likelihood of frequent visits to hospitals and emergency departments.
- **Mental Health High-Risk:** Individuals with serious mental illness (SMI) who frequently use mental health acute care services or could be placed into community mental health settings from residential facilities.
- **Substance Use Disorder (SUD) High-Risk:** Individuals with SUD who frequently visit hospitals and emergency departments.
- **Medically High-Risk:** Individuals with recurrent general acute hospital admissions.
- **Perinatal High-Risk**: Individuals who are pregnant with significant social and behavioral health problems.

Lead Entity: Los Angeles County – Department of Health Services

Estimated Total Population: 154,044 individuals over the pilot period

Budget: $630.2M in annual federal funds, matched by an equal amount of local funding provided by LAC-DHS

What health care and social service organizations are participating?

WPC-LA works with a large coalition of health and social service delivery entities countywide, including county departments, health plans, hospitals, community-based providers, and community-based non-profit organizations.

What services are included?

WPC-LA programs leverage a multidisciplinary team of individuals who address the physical health, behavioral health and social needs of our target populations through a combination of various approaches and services. Community Health Workers, who often have shared lived experiences with WPC-LA participants, are key members of our social worker-led care management teams. These unique programs seek to address the specific health challenges facing each of its target populations. Examples include a benefits advocacy program for homeless high-risk patients and a re-entry program for justice-involved high-risk patients. While the types and level of services provided vary by program and target population, each care management team engages participants, provides social support, care coordination, navigation to physical and behavioral health services, and referral to social services.

How are participants enrolled?

Potential participants are referred from health and social service delivery entities across the County, engaged by WPC-LA teams and linked to necessary services.

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How is data being shared?

WPC-LA teams use a care management platform called CHAMP for field based documentation, communication, task sharing, and information sharing. CHAMP enables care coordination between WPC team members and between WPC and non-WPC care teams. CHAMP's security environment also enables data sharing in accordance with laws and is the backbone for bidirectional data sharing between WPC-LA and other partner entities. WPC-LA is also actively working to develop an integration hub for information exchange with other county partners that do not operate using the CHAMP platform.

"Almost a third of California Medi-Cal beneficiaries, and some of the sickest, most marginalized people in the country, live in Los Angeles County. These individuals have needs across the entire spectrum. In addition to medical and behavioral health care, they need access to housing, food, income, social support, and social service organizations to help them. WPC-LA is building county capacity and helping providers and communities work together to improve the health and wellbeing of these individuals."

— Clemens Hong, Director
Whole Person Care

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.

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:

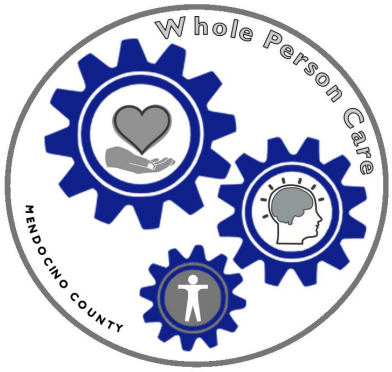
- **Comprehensive Coordination of Care:** Multi-disciplinary program staff and providers conduct meetings specific to WPC enrollees, share information amongst project partners in real-time, and collect data.

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

- **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.



- **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

Background

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Who does the program serve?

Monterey County's WPC program aims to meet the needs of some of the community's most vulnerable individuals – Medi-Cal beneficiaries who are homeless, may have a history of mental illness and substance abuse or chronic disease, and who do not have an assigned medical home. The program seeks to improve health outcomes for this population, and decrease the use of the emergency department as a source of primary care.

What health care and social service organizations are participating?

There are 13 core partner organizations that participate in Monterey County's WPC pilot program including:

Central California Alliance for Health (CCAH): Medi-Cal managed care health plan provider

Central Coast Center for Independent Living (CCCIL): Provider of rapid-rehousing and housing support strategies

CHISPA: Developer and manager of permanent housing

Lead Entity: Monterey County Health Department

Estimated Total Population: 600 individuals over the pilot period

Budget: $17 million in annual federal funds, matched by an equal amount of local funding provided by Monterey County Health Department

Coalition of Homeless Services Providers: Non-profit and public organizations working to address the complex issues of homelessness, and operator of the Coordinated Assessment and Referral System

Franciscan Workers of Junipero Serra: Operator of an emergency shelter, transitional housing, free health clinic, and day center programs

Housing Authority of Monterey County: Provider of Housing Choice Vouchers (formerly Section 8)

Interim, Inc.: Provider of residential mental health and housing services

MidPen Housing: Developer and manager of permanent supportive housing

Monterey County Department of Social Services: Providing public benefits to vulnerable persons who lack financial supports

Monterey County Health Department: Administration, Clinic Services, Public Guardian, Behavioral Health, and Public Health Bureaus providing WPC enrollee health care, case management, and pilot oversight

Monterey County Sheriff, Probation, and Public Defender offices: Referral providers of potential WPC enrollees pending release from jail and reunification for WPC enrollees lost to the system

Natividad Medical Center (NMC): County safety-net health care system

Sun Street Centers: Operator of an 8-bed sobering center

Other partners include service providers and referral agencies for homeless persons.

What services are included?

Case managers work with enrollees to establish their immediate goals and care plans, and continue to coordinate their ongoing care for 12 months. They teach patients how to navigate public systems and help them access food, housing, personal safety, and employment assistance.

WPC enrollees are assessed for physical and mental health needs. They are scheduled for medical and behavioral health visits no later than 30 days from enrollment at one of seven Monterey County Health Department clinic sites. Case managers transport and accompany enrollees to their medical appointments, and ensure they have access to medications and specialty clinical care.

Through the Coalition of Homeless Service Providers, participants complete a screening and housing assessment to understand participants' preferences and to surface any potential barriers to successful tenancy. Assessment findings are used to build an individualized housing support plan, which can include placement assistance, help with applications, and living skills.

How are participants enrolled?

Potential clients are referred to the program by Central California Alliance for Health, the four hospitals and emergency departments located within the county, and homeless services providers. Referrals are vetted and case managers work to locate individuals in the field. Potential enrollees are introduced to the program and those who enroll are assigned a team of case workers to meet their medical, mental, and substance use needs, as well as warm hand-off referrals to a coordinated and comprehensive network of supportive services.

How is data being shared?

Natividad Medical Center, county health and specialty clinics, and the public health nurse case managers operate under one county entity, which helps facilitate health data and information sharing. Hospital and emergency department data from Central California Alliance for Health and Natividad Medical Center is used to identify the highest cost, highest utilizing individuals. Monterey County is developing a secure and bi-directional electronic Master Person Index and a coordinated case management system that will link health, behavioral health, and homeless services data. The systems should be in place by the end of 2019.

Early Success:

A WPC enrollee, who had been homeless for most of his adult life and currently suffers from a heroin addiction, was identified as a high utilizer of the emergency department. The enrolle said, "the emergency room is faster than the clinics" for receiving care. As a result, the enrollee had not seen a primary care provider in over two years. A WPC Public Health Nurse Case Manager took the enrollee to a walk-in appointment at the Laurel Family Practice Clinic for wound treatment. The enrollee was seen within 15 minutes of arrival and has returned multiple times. In addition to being linked to other supportive services, the enrollee is now on the Monterey County Housing Authority's waitlist for an affordable housing unit, using federal HOME funds.

"One WPC enrollee was 57 years old and had been homeless for the past 30 years. The enrollee suffered from multiple chronic diseases resulting in over-use of hospital emergency departments for ongoing care. Since enrolling in the WPC program in October 2017, the enrollee has had no ED visits, now has a primary care provider, and has received a full range of supportive and health related resources from the WPC case nurse management team, including housing at a board and care."

— Ahkahuil Rubalcava
Nurse Case Manager
Monterey 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: Napa County

Estimated Total Population: 800 clients served over pilot period (with expansion)

Budget: $2.2 million in annual federal funds, matched by an equal amount of local funding

Who does the program serve?

Napa County WPC pilot focuses on individuals experiencing homelessness or those at risk of homelessness, including high systems users. Individuals may also have a physical disability, serious mental illness, substance use disorder or co-occurring disorders.

What health care and social service organizations are participating?

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

- Napa County Health and Human Services Agency
- Napa County Health and Human Services Agency – Mental Health
- Napa County Health and Human Services Agency – Alcohol and Drug Services
- Partnership HealthPlan of California
- City of Napa Housing Authority
- OLE Health
- Catholic Charities
- Napa Police Department
- Queen of the Valley Hospital

What services are included?

Napa County WPC pilot focuses on three primary services, interventions, and care coordination areas:

- **Mobile Engagement:** Close coordination between emergency response services and a WPC engagement team provide individuals experiencing homelessness and serious mental illness with on-the-spot assessment and referral. The engagement team works to determine whether the individual is a health plan member and their health, social, and housing needs. The team also has referral access to a sobering center, respite beds for clients discharged from the partner hospital, and coordinated entry services to facilitate the connection of participants to housing navigation, placement and tenancy care services. Peer support specialists provide street outreach, case management connections, daily living skills modeling and education, and peer-to-peer counseling.
- **Coordinated Entry:** Enhancing the existing coordinated entry system in Napa County, the WPC pilot is working to fully implement a coordinated entry approach to provide housing navigation services and client housing and care plans. Services begin with diversion, problem solving resources, and screening activities. WPC pilot personnel work with each participant individually to assess and connect participants to the ncessary services, such as food assistance programs or housing shelter resources.

Housing navigators assist in developing a housing plan for every homeless individual, including a comprehensive assessment of barriers to housing and identification of housing subsidies.

- **Tenancy Care:** Participants are assigned a care coordinator after being assessed and prioritized for housing services. Care coordinators work with homeless individuals to establish benefits, clear up credit issues, connect them to health and social services, and other necessary supports. Care is provided to participants on an ongoing basis through housing placement and stabilization activities.
- **Strenghts, Opportunities, Aspirations, and Results (SOAR) Program:** WPC has a dedicated SOAR case manager that provides benefits advocacy and supports the process of client enrollment in SSI/SSDI, including the appeals process.

Fee-For-Service offerings for WPC clients include:

- Catholic Charities' Nightingale Respite Center for clients discharged from Queen of the Valley hospital.
- McAlister Detox Center provides sobering services and bed nights for WPC clients.

How are participants enrolled?

Participants are primarily engaged and enrolled in the WPC pilot through existing workflows among partners in the homeless system. Clients can be enrolled by outreach workers in the field (including police department homeless outreach), at any of Napa's homeless shelters, the homeless drop-in day center, the medical respite center, or through the SOAR program. Designated enrollment staff at the mentioned entry points make determinations on WPC eligibility and tentatively enroll clients into the WPC program as well as into each of the program delivery bundles. WPC infrastructure staff verify Medi-Cal enrollment and confirm WPC enrollment. For non-verified enrollments, enrollment partners work with Napa County Self Sufficiency staff to connect clients to Medi-Cal enrollment and inter-county transfer services.

How is data being shared?

Napa County is in the process of establishing a data sharing and analysis platform, an internal data mart to blend internal data sets, and a secure file transfer protocol site. Most data sharing agreements and protocols have been developed, and several participating entities currently share data and information through the current data infrastructure. The county has developed a data sharing matrix, which outlines legally allowable data sharing for this program. The WPC team is collecting data from multiple sources for reporting purposes and is using the internal data mart to house and analyze this data.

The WPC program is also sharing data with external partners. Some of this data is shareable via Napa's Homeless Management Information System's (HMIS)'s release of information. Other data is shared via Business Associates Agreements (e.g. the BAA with Partnership Health) or is legally allowable without releases of information. In this case, data sharing terms are made clear through executed contracts and/or MOUs.

"We truly believe that housing is healthcare. Focusing Napa's WPC pilot on securing and maintaining housing will provide clients with the stabilizing platform needed to address complex health needs among our community's most vulnerable."

— Mitch Wippern, Chief Deputy Director
Napa County Health & Human Services Agency

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.

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

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

- 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

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

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: Riverside University Health System (RUHS)

Estimated Total Population: 38,000 individuals over the pilot period

Budget: $3.5 million in annual federal funds, matched by an equal amount of local funding provided by Riverside University Health System

Who does the program serve?

The Riverside County WPC pilot serves individuals on probation with both physical and mental health conditions and who are homeless or at risk of becoming homeless.

The WPC team developed criteria for the target population after discussions with multiple county and community partners. The highest-risk and best served population by WPC are individuals returning to the community on probation. The WPC program aims to identify insurance, behavioral, physical, social, and housing needs. CWP also aims to reduce recidivism among individuals who will be on probation for at least one full year, have multiple physical health diagnosis/chronic conditions, a mental health diagnosis, and are homeless or at risk of becoming homeless.

What health care and social service organizations are participating?

Fifteen partner organizations are participating in Riverside County's Whole Person Care program including:

MeHealth to Hope Clinics: Clinic network with three sites and mobile medical services

Inland Empire Health Plan (IEHP): Local Medi-Cal managed care plan

Loma Linda University Health: A local hospital that participates in data sharing via a shared EPIC electronic patient database

Molina Healthcare: Medi-Cal managed care plan

National Community Renaissance: National nonprofit working to develop affordable housing

Path of Life Ministries: A non-profit organization committed to serving the greater Riverside homeless population and the poor with the goal to rescue, restore and rebuild lives in our community

Riverside County Department of Public Social Services: Provides social services including public assistance to low-income and vulnerable populations

RUHS Department of Behavioral Health (DBH): DBH has developed an exceptional reputation for providing services that involve the latest innovations in clinical practices affecting mental health

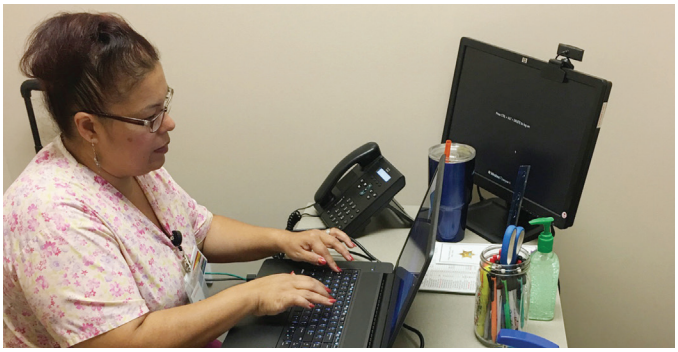
RUHS-Public Health (RUHS-PH): The local, public agency charged with ensuring the health and well-being of county residents and visitors

Riverside County Economic Development Agency: County housing authority

Riverside County Probation Department: The 2nd-largest Sheriff's Office in California, managing five correctional facilities, supervising lower-level parolees, and overseeing individuals on probation

Riverside County Sheriff's Department: Includes correctional facilities and provision of court services

Riverside University Health System (RUHS): County public health care system, includes Dept. of Behavioral Health, Dept. of Public Health, and network of Federally Qualified Health Centers (FQHCs)



The City of Riverside Mayor's Office Riverside: This office oversees the county seat and the most populous city in the Inland Empire

The California State San Bernardino Reentry Initiative: This initiative provides comprehensive, wraparound services to over 1,000 parolees per year through three locations in the Inland Empire region

What services are included?

For patients who enroll in WPC, the public health nurse will schedule an appointment at the nearest RUHS FQHC, social service office and/or Department of Behavioral Health location. Individuals are assigned a care manager and receive a personalized "Wellness Map," a technology-based tool that provides the recipient with local resources (either online or hardcopy) to assist in accessing services such as housing, physical and behavioral health care, and other supportive and social services.

How are participants enrolled?

Registered nurses are co-located in eight probation department offices. At the first probation visit, individuals recently released from incarceration are screened for needed services. Those identified with needs are provided "warm hand off" referrals to the appropriate department. Individuals with complex needs are assigned an RN Care Manager to assist in coordinating and integrating all services needed.

How is data being shared?

Riverside County's WPC program leverages existing data sharing work that began with the establishment of a Clinically Integrated Network (CIN) between RUHS, Loma Linda University Health and IEHP. The program uses a population health platform developed by Forward Health that coordinates information among all partner organizations using IEHP's population health management data and provider portal. IEHP also ensures compliance with all applicable state and federal laws.

"Many individuals leave jail without a stable home to return to, no insurance and no awareness of physical health conditions they may have. Additionally, these individuals often have needs for behavioral health and substance use. As a result, they often end up in the emergency room or return to jail soon after release. The Riverside County Whole Person Care program proactively identifies the needs of these individuals and links them to services that assist with managing conditions by providing access to supportive services, which allows them to successfully re-enter our community."

— Judi Nightingale
Director of Population Health
Riverside University Health System

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

pathways to 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.

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 Bernardino WPC pilot target population includes highest-risk, highest-utilizing patients in the county. This includes individuals who:

- Have repeated incidents of avoidable emergency room use, hospital admissions, or nursing facility placement
- Have two or more chronic conditions
- Have mental health and/or substance use disorder
- Are currently experiencing homelessness
- Are at risk of homelessness, including individuals who will experience homelessness upon release from institutions such as hospitals, rehabilitation facilities or jails

WPC enrollees include individuals who demonstrate the greatest need in these areas.

Lead Entity: Arrowhead Regional Medical Center

Estimated Total Population: 2,000 over the course of the 5-year pilot, with 500 enrolled at any given time

Budget: $2.5 million in annual federal funds, matched by an equal amount of local funding provided by Arrowhead Regional Medical Center

What health care and social service organizations are participating?

Ten partner organizations are participating in the WPC pilot, including these key partners (listed alphabetically):

- **Arrowhead Regional Medical Center:** County public health care system
- **Community Clinic Association of San Bernardino County:** Policy and advocacy organization representing community clinics and Federally Qualified Health Centers (FQHCs)
- **Inland Behavioral and Health Services:** Community FQHC that will serve as a medical home to the WPC pilot population
- **Inland Empire Health Plan:** Medi-Cal managed care plan
- **Inland Temporary Homes:** A housing services resource available to assist housing needs of target population participants
- **Molina Healthcare:** Medi-Cal managed care plan
- **San Bernardino County Department of Behavioral Health:** County specialty mental health agency
- **San Bernardino County Human Services Department:** Including multiple participating departments providing clinics, public assistance, and aging services
- **San Bernardino County Information Services Department (ISD):** County department to manage bi-directional data sharing
- **San Bernardino County Sheriff's Office:** Manages the health system in the San Bernardino County jail system

What services are included?

The pilot focuses on personalized care navigation, run by field-based mobile teams. Care navigators develop individual care plans for WPC enrollees based on need. Navigators help enrollees access existing county primary and specialty care services for both physical and behavioral health, and social services like nutritional support, education assistance, job training, and housing, as well as support from community-based organizations. Enrollees have access to assistance with daily needs, such as phone cards, bus passes, and fresh food.

How are participants enrolled?

Individuals in the target population can be enrolled during encounters with county health care or other services. San Bernardino County's WPC pilot is also designed to reach its population through other means, including relationships with the patient, family members, or support systems. Recognizing that clients may have had negative experiences with health care providers in the past, WPC patient navigators are viewed as advocates, as opposed to "clinical experts," and are trained to build a system of support around the patient.

How is data being shared?

San Bernardino procured an automated bi-directional population health system that allows all providers participating in the pilot to track and review progress and view utilization data, while complying with patient data privacy requirements. Patient navigators have immediate access to the information they need - data as well as medical, behavioral and social experts - to determine appropriate care options for their patients.

"Geographically, our county is the largest in the contiguous U.S., which presents barriers to patients in lesser-populated regions. Our Whole Person Care program has to be mobile-based, because we need to physically meet patients where they are if we're going to succeed."

— Ron Boatman
Associate Hospital Administrator
Arrowhead Regional Medical Center

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.

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

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.

San Francisco's WPC program serves the city/county's homeless adult population. The program uses a multi-agency universal assessment tool that gives every homeless adult in San Francisco a health assessment and health record, and stratifies individuals into risk categories that will guide the intensity of interventions.

Who does the program serve?

San Francisco's WPC pilot aims to create a system of care that can respond to our homeless population no matter what door they enter and no matter what their insurance status is. Half of the homeless enter WPC through the treatment system, one quarter through the housing system and the final quarter through both. Once identified as homeless, the individual is welcomed and if, a Medi-Cal recipient, they are flagged as an enrollee of WPC for billing purposes.

San Francisco reviewed historical data captured in its pioneering Coordinated Care Management System (CCMS) and identified three categories of WPC enrollees based on acuity and need:

- Severe Risk: Homeless more than ten years and high utilizer of urgent/emergent care
- High Risk: Either homeless more than ten years or high utilizer of urgent/emergent care
- Elevated Risk: All other homeless adults

Lead Entity: San Francisco Department of Public Health (SFDPH)

Estimated Total Population: 17,000 individuals over the pilot period

Budget: $161,750,000 in federal funds, matched by an equal amount of local funding provided by SFDPH

What health care and social service organizations are participating?

Ten partner organizations are participating in San Francisco County's WPC pilot project, including:

- **Anthem Blue Cross Partnership Plan:** Medi-Cal managed care plan that has more than 25 years of experience administering Medicaid and state-sponsored programs.
- **Baker Places:** Non-profit, community-based agency that provides transitional residential treatment services as an alternative to long term care in state hospitals.
- **Department of Homelessness and Supportive Housing:** City/county housing agency, with the singular focus on addressing homelessness in San Francisco.
- **Health RIGHT 360:** Network of health clinics and behavioral health programs.
- **Human Services Agency:** Social services and public assistance.
- **San Francisco Department of Aging and Adult Services (DAAS):** This department plans, coordinates, and advocates for community-based services for older adults and adults with disabilities.
- **San Francisco Department of Public Health (SFDPH):** City/county health services agency providing comprehensive health care, including primary care clinics, Zuckerberg San Francisco General Hospital and Trauma Center, and Laguna Hospital Long Term Care facility.
- **San Francisco Health Network Behavioral Health Services (BHS):** BHS operates the County Mental Health Plan, Jail Behavioral Health Services, and provides San Franciscans with a robust array of services to address mental health and substance use disorder treatment needs.
- **San Francisco Health Plan:** Medi-Cal managed care plan that currently enrolls 86% of the city's Medi-Cal managed care members.

What services are included?

San Francisco has designed a universal assessment tool to ensure that every homeless adult in San Francisco will have a multi-disciplinary assessment and a shared care plan. The results will help the pilot stratify and prioritize individuals into risk categories to guide the intensity of health and housing interventions provided.

Enrollees receive screenings and enrollment assistance for Medi-Cal and other public benefits including comprehensive medical, behavioral health, and social services (e.g. homeless services, housing supports, and care coordination).

The WPC pilot also developed navigation centers, which function as resource centers during the day and specialized shelters at night. Other services include an expansion of medical and mental health respite services, substance abuse services, transition care for seniors and our peer navigator services.

San Francisco's Homeless Health Resource Center will provide wraparound services for people experiencing homelessness who are unable to navigate the primary care and behavioral health system. In addition to having services coordinated such as coordinated housing entry and benefits navigation, the Homeless Health Resource Center serves as a full service, one-stop respite and WPC Health Center. It offers patient-centered and trauma-informed care coordination throughout all services, and is organized to maximize access and acceptability.

How are participants enrolled?

Participants identified as homeless adults with Medi-Cal are enrolled in WPC (note: ALL homeless adults will be served despite Medi-Cal eligibility). Clients receive a welcome notice.

How is data being shared?

CCMS centralizes, matches, and merges over twenty years of essential health, behavioral, and social information on vulnerable adults in San Francisco who access public healthcare services. Under WPC, the system is being updated to allow other participating entities protected access to this information. Clinicians and case managers will be able to coordinate care through the platform's interface.

"The idea of Whole Person Care has been percolating at SFDPH for years. We first identified HUMS (High Users of Multiple Systems) in 2007 as San Francisco's highest-need and highest costing patients when we merged multiple health and social data sets through our Coordinated Care Management System. Whole Person Care provides the structure and resources to push us to the next level, and creates the imperative for our health, housing and benefits partners to work together in a human-centered fashion."

— Maria X. Martinez
Director, Whole Person Care
San Francisco Department of Public Health

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?

San Joaquin County's WPC program targets the needs of three potentially overlapping populations: (1) Medi-Cal beneficiaries assigned to the County clinic system who are high-utilizers of emergency services; (2) adult Medi-Cal beneficiaries with a mental health and/or substance use disorder; and (3) adult Medi-Cal beneficiaries who are at risk of homelessness upon discharge from WPC-participating medical facilities or the county jail.

What health care and social service organizations are participating?

Fifteen partner organizations are participating in San Joaquin County's WPC pilot project including:

Central Valley Low Income Housing Corporation (CVLIHC): Supportive housing program provider that provides tenancy based support and outreach services

Community Medical Centers (CMC): Federally Qualified Health Centers (FQHC) supporting the greater Stockton area

Correctional Health Services (CHS): Provides health care services within the County Jail and helps enroll clients and provide transitional case management services via 30 day follow-up post release

Lead Entity: San Joaquin County Health Care Services Agency

Estimated Total Population: 2,255 individuals over the pilot period

Budget: $1.8 million in federal funds, matched by an equal amount of local funding provided by San Joaquin County Health Care Services Agency

Dignity Health: St. Joseph's Medical Center: Community partner and largest hospital in county

Gospel Center Rescue Mission: Non-profit program offering homeless individuals a safe place to recuperate while completing their medical recovery after being released from the hospital

Health Net: Commercial Medi-Cal Managed Care Health Plan

Health Plan of San Joaquin (HPSJ): Local Initiative Medi-Cal Managed Care Health Plan and primary partner in WPC Pilot

Housing Authority of the County of San Joaquin: County's Housing Authority who will administer the pilot's housing activities

San Joaquin Community Health Information Exchange (SJCHIE): Locally-governed non-profit health information exchange organization

San Joaquin County Clinics (SJCC): County FQHC look-a-like clinic system aligned with County's public health care system, San Joaquin General Hospital

San Joaquin County Behavioral Health Services (BHS): County's Specialty Mental Health department provides outreach and services to WPC clients with mental health needs

San Joaquin County Health Care Services Agency (SJHCSA): County's Health Care Services Agency and lead entity for WPC Pilot

San Joaquin County Public Health Services (PHS): Builds community based care management entity capability and provide nursing support

San Joaquin County Substance Abuse Services (SAS): Provides ASAM based treatment services to WPC clients

San Joaquin General Hospital (SJGH): County public health care system that provides primary care, inpatient, specialty and emergency department services to WPC clients

What services are included?

The pilot utilizes a multi-disciplinary "Whole Person Care Integration Team," which creates an individualized care plan for each enrollee, based on an assessment of his or her physical health, behavioral health, and social support needs. The care plan is shared across agencies and each client is assigned a single dedicated care coordinator, whose location is determined based on the needs of the patient.

The team engages clients in three phases. In the first phase, care coordinators reach out to clients two to five times per week, ensuring that they are linked to medical services and social supports, and receiving assistance with Medi-Cal enrollment. When appropriate, the second stage of care focuses on maintaining care and linkage to support services, and providing education around daily living activities, medication adherence, and crisis management. The last phase focuses on life skills development and transitioning to less-intensive care as clients' health and well-being improves.

The pilot uses a county flexible housing pool (with funds not provided by the WPC program) to assist with the housing needs of enrollees, including rental assistance vouchers.

How are participants enrolled?

San Joaquin County's WPC pilot engages and enrolls participants at the time of discharge from a facility such as jail or a participating hospital's emergency department, or through referrals from community partners for individuals who are in crisis or need immediate assistance. A mobile homeless support team also conducts outreach to homeless individuals and enrolls them into WPC to address immediate mental and physical health care needs.

How is data being shared?

The San Joaquin Community Health Information Exchange (SJCHIE) is a 501c3 corporation governed by a Board of Directors comprised by senior leadership from each of the founding WPC member organizations, all listed above as participants: SJHCSA, BHS, SJGH, SJCC, HPSJ and CMC. The WPC pilot works with SJCHIE to create a system for participating organizations to enter information about treatment, care management, coordination, and monitoring. This information is accessed by care coordination teams and utilized to ensure patients' needs are being met.

"Our success in connecting with our patients early and often will be crucial to improving the health of our Whole Person Care clients. Regular contact builds trust and a good rapport, and helps lead to voluntary treatment and social support assistance."

— Greg Diederich, Director
San Joaquin County Health Care Services

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 with 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 and 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 participating 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

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). CCSP, 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

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: Santa Clara Valley Health and Hospital System (SCVHHS)

Estimated Total Population: 10,000 over the course of the 5-year pilot

Budget: $25 million in federal funds, matched by an equal amount of local funding provided by SCVHHS

Who does the program serve?

The Santa Clara County WPC pilot target population includes high utilizers of health and behavioral health services. To identify eligible individuals, Santa Clara Valley Health and Hospital System's (SCVHHS) Center for Population Health Improvement aggregated data from across SCVHHS departments and Valley Health Plan (the county's managed care plan). A point system was developed to assess which individuals would benefit most from WPC. The point system measures usage of emergency, inpatient, and urgent care systems, with a higher point value assigned to emergency psychiatric and medical encounters. Partner organizations also identified sub-groups of the target population who may have been excluded in these calculations due to justice involvement, a lack of access to care, or other circumstance.

What health care and social service organizations are participating?

The partner organizations participating in Santa Clara County's WPC pilot project include:

- **Anthem-Blue Cross:** Medi-Cal managed care plan for 73,886 enrollees in the county
- **Behavioral Health Contractors Association:** Network of community-based behavioral health providers
- **Community Health Partnership:** Consortium of nine community health centers
- **County of Santa Clara Office of Supportive Housing:** County supportive housing agency
- **Custody Health Services:** Custody Health Services provides care to over 55,773 inmates annually, of which over 18% have a serious mental illness
- **El Camino Regional Hospital:** Nonprofit hospital in Santa Clara County
- **Hospital Council, Santa Clara Section:** Consortium of 12 hospitals in county
- **Housing Authority of County of Santa Clara:** County housing authority assists about 17,000 households through the federal rental housing assistance
- **Roots Community Health Center:** Community organization that provides care coordination and complex care management services targeting WPC patients of African descent
- **Santa Clara County Probation Department:** Reduces crime and protects the community through prevention, investigation and supervision services and safe custodial care for adults and juveniles
- **Santa Clara County Public Health Department (SCCPHD):** Focuses on protecting and improving the health of communities through education, promotion of healthy lifestyles, disease and injury prevention, and the promotion of sound health policy
- **Santa Clara County Office of Reentry Services:** Resource centers that support previously incarcerated individuals
- **Santa Clara County Social Services Agency:** A culturally sensitive and socially responsible public agency providing high quality, professional, financial, and protective services to low-income individuals and families
- **Santa Clara Family Health Plan (SCFHP):** Medi-Cal managed care plan
- **Santa Clara Valley Medical Center:** County public health care system that is dedicated to the health of the whole community by providing high quality, cost-effective medical care to all residents

- **Santa Clara Valley Behavioral Health Services Department:** Provides an extensive array of services for adults, transitional aged youth and older adults through outpatient services at county sites and contract agencies
- **The Health Trust:** Health care service provider
- **Valley Health Plan:** Managed care plan owned and operated by the County

What services are included?

The WPC pilot is designed to address gaps in the existing service system and provide coordinated services to help the target population access and navigate existing services.

As part of WPC implementation, and in response to the needs of enrollees, the pilot has developed an array of services including:

- New/expanded wellness and health promotion activities to support prevention and engagement in healthcare
- Increased access to skilled nursing facilities for participants with complex medical/psychiatric needs
- Medical respite care for those participants without appropriate home care
- Peer respite for those experiencing mental health crisis
- A sobering center as an alternative to custody or emergency services for inebriated participants.

The targeted care coordination model is based on the anticipated needs and duration of patients in the WPC program. For example, "short-term" patients receive help with care transitions and "mid-term" patients receive help stabilizing complex cases and addressing social barriers to recovery, including housing instability. "Long-term" patients, who are unlikely to achieve independence without ongoing services, receive more hands-on care coordination. This includes maintaining engagement and nursing home transition patients who require intensive care coordination to avoid institutionalization and support community living.

How are participants enrolled?

Individuals eligible for WPC are notified by mail. Those individuals without a current mailing address are engaged directly when they visit a participating organization. Care coordinators also engage patients who have been identified as eligible at locations frequently visited by those in the program's target population, including parks and churches.

How is data being shared?

The Trust Community is a WPC data sharing system which facilitates data integration among internal and external partners. It is designed to allow WPC partners to access utilization data and data for patient intervention planning efforts, as well as analytical tools to measure performance and outcomes.

Additionally, Santa Clara's WPC pilot is working to improve the quality of services provided to enrolled patients. "Plan Do Study Act" quality improvement activities are currently being implemented to test change at Santa Clara Valley Health and Hospital System and with contracted community partners.

"We have incredible backing from our community, with sixteen official partners and seventeen more organizations that are supporting our efforts. With so much to offer, we can truly tailor our efforts to meet the unique needs of each individual who is part of this program to achieve better health."

— Amy Carta
Assistant Director
Santa Clara Valley Health and Hospital System

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?

Santa Cruz County's Whole Person Care pilot, WPC - Cruz to Health, serves individuals with a mental illness and/or substance use disorder, and other co-occurring risk factors including chronic physical conditions, repeated hospitalizations, criminal justice history, institutional living, and/or homelessness or at risk for homelessness. Participants must be Adult Medi-Cal beneficiaries who receive their primary care at one of the County of Santa Cruz Health Services Agency Clinics.

What health care and social service organizations are participating?

- **County of Santa Cruz Health Services Agency:** County health care system; includes Behavioral Health Division, Clinics, and Public Health Division, including Emergency Medical Services
- **Central California Alliance for Health:** Local Medi-Cal managed care organization
- **Santa Cruz Health Information Organization:** Local health information exchange organization; one of the oldest exchanges in the country
- **Dignity Health Dominican Hospital:** Local safety net hospital
- **Watsonville Community Hospital:** Local safety net hospital
- **Telecare:** Local psychiatric hospital
- **Housing Authority of the County of Santa Cruz:** Housing services organization; provides rental subsidies, manages and develops affordable housing for low income families, seniors, and persons with disabilities
- **Santa Cruz County Human Services Department:** Provides eligibility and enrollment into public benefits to help meet basic needs of individuals and families

Lead Entity: County of Santa Cruz Health Services Agency

Estimated Total Population: Up to 1,000 individuals, which is approximately 1.5% of the county's Medi-Cal population, and 0.38% of the county's overall population of 262,382

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

- **Santa Cruz County Probation Department:** Works with justice-involved individuals
- **Health Improvement Partnership of Santa Cruz County:** Local nonprofit coalition of public and private health care leaders dedicated to increasing access to health care and building stronger local health care systems
- **Front Street Inc.:**Behavioral health contractor that offers quality residential programs and mental health treatment services to adults and older adults

What services are included?

WPC Cruz to Health includes two care management bundles (Behavioral Health and Clinical) and two tiered housing support bundles (Intensive and Intermediate). In addition to service bundles, WPC - Cruz to Health also offers fee-for-service housing support to help homeless individuals transition into housing.

County Specialty Mental Health clients enrolled into the program receive the Behavioral Health Bundle, and all County Clinic clients enrolled into the program receive the Clinical Bundle. The Behavioral Health Bundle includes an intensive support team contracted to assist participants with their goal to live successfully in the community, to manage their own medications, and be engaged with meaningful daily activities that may include work or school.

WHOLE PERSON CARE
CRUZ TO HEALTH

The Clinical Bundle provides case management and care coordination in the primary care setting and medical oversight for a new telehealth program. WPC - Cruz to Health enrollees qualify for an in-home telehealth device to help manage and monitor their chronic conditions (e.g. diabetes, depression). The Clinical Bundle also includes pilot program operations and the development of information technology infrastructure required between different data systems for improved care coordination.

The intensive Housing Support Bundle is available for participants who are currently homeless or who demonstrate poor housing readiness skills, including a poor history of community tenure or ability to remain in housing (e.g. multiple evictions, frequent tenant or community complaints, acuity level of mental illness and/or substance use). Intensive housing support includes a housing navigator and peer support services which will involve contact with the individuals up to two times daily.

The intermediate Housing Support Bundle is available for participants who no longer require intensive Housing Support services. Intermediate Housing Support services will involve contact with individuals up to two times weekly.

Housing assistance includes one-time housing transition costs, such as security deposit and utilities set-up charges to help address barriers to housing. Homeless individuals enrolled in the program receive up to $4,500 per member.

How are participants enrolled?

WPC - Cruz to Health uses data from internal electronic health record databases to identify individuals eligible for the program. The program also receives direct referrals from internal providers and external community partners. Eligible referrals are administratively enrolled followed by a consent to release information to allow providers to communicate about an enrollees' complex needs.

How is data being shared?

The WPC - Cruz to Health pilot aims to expand the County's existing shared data platform, Santa Cruz County's Health Information Exchange (SCHIE). SCHIE is one of the oldest and most advanced multi-stakeholder exchanges in the country. WPC - Cruz to Health's data-sharing goals include:

- On-boarding cross sector service providers essential to addressing underlying causes of poor health outcomes
- Building bi-directional interfaces for participants including safety net hospitals, clinics, the local health plan, and behavioral health providers
- Developing a notification and alerting system for improved care management and coordination between hospitals, primary care, the local health plan, behavioral health, and social services
- Creating a care management data system to share care plans across participating organizations
- Building a "whole person" dashboard, a closed-loop referral management system, and pathways to individual medical records in the SCHIE clinical data repository
- Developing population health analytics and reporting dashboards for tracking health outcomes of WPC - Cruz to Health participants

"Whole Person Care - Cruz to Health is an innovative approach to improving care coordination and health outcomes for our most vulnerable community members through evidence-based interventions and progressive data sharing strategies. By breaking down silos and streamlining communication across multiple systems, WPC - Cruz to Health lays a foundation for improved care and health outcomes for all members of our community."

— Giang Nguyen, Agency Director
County of Santa Cruz Health Services Agency

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.

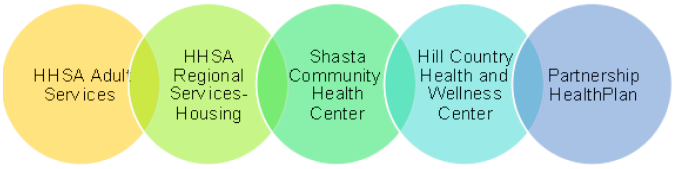
Who does the program serve?

The Shasta County WPC pilot target population includes Partnership Health Plan members who are homeless or at risk of homelessness and had two or more emergency department visits or a hospitalization in the last three months. In addition, the target population may have one or more of the following risk factors: a diagnosis of serious mental illness, a diagnosis of substance use disorders, or an undiagnosed opioid addiction.

What health care and social service organizations are participating?

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

- Shasta County HHSA Adult Services
- Shasta County HHSA Regional Services- Housing Programs
- Shasta Community Health Center
- Hill Country Health and Wellness Center
- Partnership HealthPlan of California



Oversight and guidance are provided by the Shasta Health Assessment and Redesign Collaborative (SHARC), which includes participating entities, public agencies, and community partners.

Lead Entity: Shasta County Health and Human Services Agency

Estimated Total Population: 600 clients served over pilot period

Budget: $1.9 million in annual federal funds, matched by an equal amount of local funding

What services are included?

The WPC pilot focuses on the following key services, interventions, and care coordination strategies:

- Screening and enrollment in the WPC pilot program and referral to a Teamlet comprised of RN, medical case manager, and a housing case manager
- Development of a hub for behavioral health, assisted outpatient treatment, pre-crisis, and social non-medical services through development of a mental health resource center
- Mobile crisis team to divert individuals experiencing acute mental health crises away from the emergency department and law enforcement and into treatment by providing timely professional intervention in the field
- Intensive medical case managers to provide care coordination to connect WPC participants to needed primary care and specialty care, non-medical social services, track referrals, and assist patients in accessing needed care
- Linkages to residential and outpatient substance use disorder services

- Coordinated entry approach to housing services with housing case managers that assist participants in overcoming housing barriers. This service helps participants find and maintain stable housing to better address support substance use disorder treatment, as well as medical and behavioral health care goals

The WPC pilot aims to connect participants to a patient centered health home, which provides case management to support clients in accessing medical and social services and stabilize patients' health needs and chronic conditions. Services provided include regular and timely access to medical services, support of clients' substance use treatment goals, and coordination with local housing case managers and housing assistance programs to connect clients to stable housing.

How are participants enrolled?

Referrals are generated via key community partners (hospitals, SUD providers, mental health providers, etc.) and the referral form is submitted to the WPC administrative team. Once eligibility is verified, the potential participants are assigned to a Teamlet. The Teamlet coordinates an outreach and engagement strategy and develops a comprehensive care plan with the patient. Patients also have the option to opt out of WPC.

How is data being shared?

The WPC pilot utilizes several sources of data: 1) health claims data from Partnership Health Plan of California; 2) electronic health records maintained by Shasta County HHSA and FQHCs; 3) program reports from case managers and pilot partners; and 4) Homeless Management Information System.

To be enrolled in WPC, each participant signs a multi-party, bi-directional release of information. This enables the pilot team to coordinate care, share participant information amongst the members of the Teamlet and between health systems and providers for outreach and engagement activities, case management, service delivery and reporting and tracking purposes. Data management and sharing activities are expected to be ongoing during the pilot period.

"Whole Person Care has facilitated a paradigm shift in our concept of collaborative, client centered, treatment services. This enhanced collaboration is helping us better serve those in our community who are most in need."

— Dean True
Shasta County HHSA- Adult Services Branch Director

WHOLE PERSON CARE

Small County Collaborative

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?

Broadly, our teams serve individuals with complex health needs that use emergency and hospital care services routinely. Homeless individuals and individuals with mental health and/or substance use disorders are prioritized.

What health care and social service organizations are participating?

There are 30 partners across three counties that comprise the Collaborative. Key partners include:

- Anthem Health Plan
- California Health and Wellness
- John C. Fremont Healthcare District
- Alliance for Community Transformations
- Seneca Healthcare District
- Plumas District Hospital
- Eastern Plumas Healthcare
- Plumas Rural Services
- Hazel Hawkins Hospital
- San Benito Health Foundation

What services are included?

Comprehensive care coordination is provided for eligible individuals. Using the recovery model, care coordinators will conduct a strength assessment of the life domains of the participant. A care plan is developed that reflects the specific needs of the participant including health, mental health, substance abuse and housing needs. This approach includes assembling a care team of individuals related to the participant's care plan goals with the joint purpose of working with the participant to improve health, recovery and life outcomes. Through intense care coordination, the participant can more easily access services such as housing supports, respite care, sobering, behavioral health and primary care. An incentive and pay for outcomes structure was created to encourage hospital participation as well as a shared ownership of the work to improve health outcomes.

Lead Entity: San Benito County Health and Human Services Agency for the California Small County Collaborative (CSCC), which includes San Benito County (Health and Human Services), Mariposa County (Human Services - Behavioral Health) and Plumas County (Behavioral Health)

Estimated Total Population: 427 individuals, which is 1.4% of the Medi-Cal population across three rural counties

Budget: $1 million in annual federal funds, matched by an equal amount of local funding

How are participants enrolled?

Community partners, county agency partners and county lead agency staff perform outreach and engagement to the targeted population. An existing referral structure was leveraged to create a pipeline between social service and health entities to WPC. An incentive structure was created to compensate organizations and agencies for their work to identify and refer potential participants. Participants must meet a number of requirements to be eligible for WPC.

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

How is data being shared?

The California Small County Collaborative (CSCC) evaluated and chose a software vendor to create an e-client management system. This system enables the County Lead Agencies to:

- Aggregate, integrate and follow target participant data and utilization across systems and time. In phase II of system implementation, we are hoping to automate data integration such through Application Programming Interface (API), from a variety of systems including Medi-Cal Managed Care Plans, hospitals, County Behavioral Health, and community-based providers
- Capture diagnostic information to identify multiple conditions
- Capture non-health care information, including homelessness and justice system interaction
- Provide a mechanism for managing Comprehensive Care Coordination Plan and coordinating and documenting services provided to WPC participants
- Provide participant-level and population-level data reporting to monitor participant and population progress and support quality improvement efforts

This system also provides permission level access to our partners for charting progress and reviewing pertinent data. This is a crucial feature structured to help us obtain real-time participant information. This will enable the Care Team to offer the highest quality care to our participants to help them achieve their wellness goals.

"In a rural county, it has been challenging in the past to meet client needs. However, the Whole Person Care project has helped each Community Partner really take a look at how we can work as a collaborative team to ensure a client's individual needs are met."

— Tori Brown, Senior Case Manager CATC
Plumas 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: Solano County Health & Social Services

Estimated Total Population: 250 clients served over pilot period

Budget: $466,701 in annual federal funds, matched by an equal amount of local funding

Who does the program serve?

The Solano County WPC pilot targets individuals with high medical utilization, repeated incidents of avoidable emergency department use, and two or more chronic and serious health conditions. At least one of which are mental health and/or substance use disorders. Many individuals in the target population are either homeless or at high risk of homelessness.

What health care and social service organizations are participating?

Ten entities, including health and social service organizations, are participating in WPC:

- Solano County Health & Social Services
- Partnership HealthPlan of California
- Solano Coalition for Better Health
- NorthBay Medical Center/NorthBay VacaValley Hospital
- Kaiser Permanente Vallejo Medical Center/Kaiser Permanente Vacaville Medical Center
- Bay Area Community Services
- Fairfield Housing Authority
- La Clinica de la Raza Community Medical Centers, Inc.

What services are included?

The WPC pilot provides a wide range of services and an extensive team of providers and entities that offer participants creative and innovative interventions. Services include:

- Participant engagement: Community Health Outreach Workers (CHOWs) identify and enroll potential participants, refer individuals to services and resources, and coordinate care.
- Comprehensive, Person-Centered Multi-Modal Screening Tool: Participants are screened for medical and behavioral health issues by a CHOW within the community health centers. Participants are provided services quickly to secure health, mental health, housing, and social services needs.
- Complex Care Coordination (CCC): CCC provides comprehensive case management for medical and behavioral health services for WPC participants in home and community settings. Activities address participant needs across all major dimensions of care, including self-care, disease management, treatment adherence, follow-through, obstacles that need to be addressed by the provider team, and overall utilization, and progress.

Community Connections
A project of Solano Coalition for Better Health and Solano County Health & Social Services

- Field Outreach and Linkage: Coordination between WPC pilot entities allows participants to receive priority service access in the Federally Qualified Health Center, mental health, and substance use programs. Participants are linked to community-based resources through assertive outreach, appointment facilitation and completion assistance, miscellaneous care support, and participant engagement services.
- Mental Health and Substance Use Treatment and Co-occurring Peer Support: Services include a harm-reduction approach that provides individually-tailored field-based and clinic-based engagement, treatment, relapse prevention, and relapse recovery services to participants.
- Housing and Social Service Assistance: Housing advocacy and support services provided to participants through housing resource specialists. Solano County has allocated 10 housing slots to individuals participating in the WPC pilot (funded separately from the WPC pilot budget). Social service assistance, including food services, transportation resources, and community-based organization referrals, are also provided to participants.

How are participants enrolled?

Participants are identified via a list provided by Partnership HealthPlan of California, as well as, other sources including CHOW outreach. Engagement specialists work directly with individuals to enroll in services, facilitate appointment attendance and completion, and engage participants through motivational interviewing, shared experience, and caring and compassionate contacts.

How is data being shared?

Data sharing is facilitated through a health information exchange that includes information on participants' treatment plan, assessment information, and progress notes. A new clinical collaboration software tool is also currently under development, which will allow WPC pilot participating entities to easily communicate, summarize, and update care events with the collaborating team of providers and entities. Information sharing is governed by memoranda of understanding (MOUs) with each participating entity.

"We find the value of sharing information across agencies beneficial. We are now starting to build strong linkages among different service sectors to address upstream social factors thereby improving our community's health outcomes."

— Jayleen Richards, Public Health Administrator
Solano County Health & Human Services,
Public Health Division

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?

Ventura County's WPC pilot targets the needs of high-utilizing beneficiaries of Gold Coast Health Plan, the county-organized Medi-Cal managed care health plan. These patients are defined as having four or more emergency department visits and/or two or more inpatient admissions in a year. Nearly all of these patients have multiple chronic conditions. Approximately 40% have mental health disorders and 25% are either homeless or have a substance use disorder.

What health care and social service organizations are participating?

Eighteen partner organizations are participating in Ventura County's WPC pilot project including:

Area Housing Authority of the County of Ventura: This county housing authority aims to be a leader in providing assistance to people in need of affordable housing through development, acquisitions, and partnerships.

FOODShare, Inc: A community organization that distributes millions of pounds of healthy food every year.

Gold Coast Health Plan: Medi-Cal Managed Care Plan.

Interface Children & Family Services: A local non-profit social services agency that provides comprehensive, direct, and responsive wrap-around services to address complex needs for clients.

Jewish Family Services: A faith-based charity with a mission to encourage and support the quality and continuity of individual, family, and community life.

National Health Foundation: A community organization aimed to improve the health of individuals and underserved communities by taking action on the social determinants of health.

Not One More: A non-profit community organization dedicated to providing support to community members and their families who are struggling with addiction.

Lead Entity: Ventura County Health Care Agency

Estimated Total Population: 2,280 individuals over the pilot period

Budget: $10.8 million in federal funds, matched by an equal amount of local funding provided by Ventura County Health Care Agency

Project Understanding: A community organization focused on ensuring that homeless and at-risk families are housed and fed.

Ventura County Continuum of Care Alliance: County coalition of homeless service providers committed to ending homelessness.

Ventura County Health Care Agency (VCHCA): County public health care system, which includes key partners Ventura County Behavioral Health Department (VCBH), Ventura County Public Health Department (VCPHD), and Ventura County Medical Center (VCMC) and Ventura County Ambulatory Care, network of primary and specialty clinics.

Ventura County Human Services Agency: Public service provider assisting with food, housing, health care, and employment.

Ventura County Probation Agency: Law enforcement agency supervising individuals on probation.

Ventura County Rescue Mission Alliance: A faith-based non-profit charity that offers refuge, recovery, and restoration services.

Ventura County Salvation Army: A faith-based charity with a focus on feeding the hungry, housing the homeless, and changing the lives of individuals and families.

Ventura County Sheriff's Office: Provides traditional police services and maintains county jail system.

Ventura County St. Vincent de Paul: A faith-based charity that offers tangible assistance to those in need on a person-to-person basis.

Ventura County Transportation Commission: Regional transportation planning agency.

Workforce Investment Board: This county board aims to have a high-quality, appropriately skilled workforce that is ready and able to support the changing business needs of employers in a dynamic, competitive, global economic environment.

What services are included?

WPC participants receive individualized integrated care plans, managed by trained community health workers who speak the same languages and come from similar backgrounds as program participants. They aim to provide patients with sensitive and appropriate care. These community health workers are part of a care coordination team, which includes care managers, nurses, and behavioral health specialists. All team members receive training to support their ability to meet the needs of this specialized population including team-based care, trauma informed care, motivational interviewing, mental health first aid, and crisis prevention training. A daily huddle supports the delivery of team-based care and a culture of patient safety.

Participants receive trauma-informed, patient-centered care provided by a multidisciplinary care team from Ventura County Health Care Agency's FQHCs, hospitals, and specialty care providers as well as the County Behavioral Health Department for mental health and alcohol and drug services.

The team ensures that participants receive vital social services and supports, such as shelter and housing transition and tenancy services, as well as transportation, healthy food, clothing, and personal hygiene supplies. Life skills and job readiness training are available as participants improve and transition to self-sufficiency.

Homeless participants can receive services through "Mobile Outreach Care Pods" that provide showers, limited scope medical services, and other offerings from a host of County agency and community social service partners geared towards meeting immediate needs and putting participants on a path towards stability. Recuperative care provides a safe place for homeless individuals to recover following hospitalization, so they are not discharged to the streets or other unsafe living conditions.

How are participants enrolled?

Eligible participants are pre-identified based on health plan data and flagged in a health registry, so that any provider (not just partner organizations) are notified and able to offer the appropriate referrals. Field outreach is also conducted in community clinics, shelters, and homeless encampments to reach eligible individuals who are not yet enrolled. Nurses also engage potential enrollees at mobile shower stations operated by VCHCA, which are made available periodically at different locations.

How is data being shared?

Medical, behavioral and social service data is stored in a data warehouse and can be accessed and updated by WPC partners. This allows members of the care coordination team to effectively manage each patient's care. Ventura County's WPC pilot is working towards utilizing a web-based platform that can be used as a telemedicine consultation system and a patient registry. A data governance committee helps ensure information shared across providers and disciplines is accomplished within the bounds of existing legislation and ethical standards.

Early Success:

In September 2017, WPC received a referral from Pathways Recuperative Care for John Chavez, a 49-year-old homeless man, recovering from wounds and a serious infection on his leg. WPC's care coordinator, Reuben Juarez, met with him that day. After learning that Mr. Chavez wanted to get clean and leave his life on the streets, Reuben connected him to a sober living home.

Five months later, Mr. Chavez has a positive outlook on life, is living sober, working and seeing a primary care doctor. Describing his experience, Mr. Chavez says he "...was looking to change and was fortunate to have met the right people... Reuben is special to me."

"Regular and early engagement in a well-coordinated environment is necessary to improve the health and lives of our most vulnerable. If those lines of communication are kept open – between our team and the patient, and between partner organizations – we can better determine and meet each person's specific needs, improve their health, and help prevent overutilization."

— Johnson Gill, Director
Ventura County Health Care Agency

CALIFORNIA'S WHOLE PERSON CARE (WPC) PILOT PROGRAM:

"Tough times don't last; tough people do."
— Placer County WPC Participant

"I could relate to her situation, based on my own lived experience. I empathize with how difficult it has been for her to recover without support from society. This is something that I cherish about being a Community Health Worker- that I can relate to her and walk her through these processes to get her to where she wants to be holistically."

— Joanne Westpoint, Los Angeles County WPC Community Health Worker

"The Whole Person Care pilot considers a comprehensive care approach to address several social determinants of health affecting the most at-risk population at the same time. This compels multiple entities in Solano County to combine efforts and create lasting solutions to benefit the entire population."

— Jayleen Richards, Public Health Administrator Solano County Health & Human Services

Going Beyond Medical Services to Help Vulnerable Californians Lead Healthy Lives

"It is an honor to have Miss Angel as part of my journey, who showed me the way to go. Whose strength and compassion has held me in my recovery. She really is my Angel. Thanks to her I got into a treatment facility, and prior to that I had no medical care. Within a week she helped me apply for benefits and has been part of my support system."

— Los Angeles County WPC Participant

"We take pride that our pilot program is built on partnerships with local agencies and nonprofits. People from across the county are rolling up their sleeves and becoming part of Whole Person Care."

— Rob Oldham, Director of Public Health, Placer County

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