WHOLE PERSON CARE

Alameda 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?

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

WHOLE PERSON CARE

Alameda County

- **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