WHOLE PERSON CARE

Contra Costa 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: 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

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
- **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

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What services are included?

CommunityConnect's enhanced and coordinated case management model provides medical, behavioral health, social services including support for 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 such as 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