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