For people in low-income communities, medical problems can be caused and exacerbated by factors related to poverty such as poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity.

**Whole Person Care (WPC)** recognizes that the best way to care for people with complex needs is to address their full spectrum of care, including medical, social, and economic. WPC has two primary goals:

- Build partnerships and develop infrastructure to coordinate care seamlessly across providers, including health care systems, social services, behavioral health, law enforcement, managed care plans, and community-based organizations.
- Provide tailored, integrated care for high-risk individuals to improve health.

In 2016, 25 WPC pilots were selected by California's Department of Health Care Services (DHCS) as part of the Medicaid 1115 Waiver. Since then, over 100,000 patients have enrolled in WPC across the state.*

**Core Interventions and Services**

**Supportive Housing Services**

Patients are connected to a range of supportive housing services, including housing navigators, financial assistance for security deposits and move-in fees, and support maintaining relationships with landlords.

**Behavioral Health & Substance Use Disorder Treatment**

Each patient is screened for behavioral health needs and linked to the appropriate level of care, including detox and rehabilitation centers, medication assisted treatment, psychiatric respite, and intensive outpatient services.

**Community Re-entry after Jail**

Care teams intervene at the time of release to help parolees transition safely to the community by connecting them to case management, medical care, and housing options.

**Shared Care Planning**

WPC streamlines the care planning process so that each patient has a single, comprehensive care plan, accessible by every member of the care team across partner organizations.

**Engaging the Most Vulnerable**

By employing a talented workforce of community health workers and peer navigators, WPC draws on the lived experience of staff to foster trust with vulnerable patients and actively engage them in self-care.

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*Data from December 2018.*
WPC Progress to Date

In the early years, WPC focused on building partnerships and developing infrastructure to coordinate care across providers. Below are examples of early successes:

- 75% of pilots opened or expanded post-acute facilities and/or temporary housing, including medical and psychiatric respite, low-threshold homeless shelters with on-site intensive case management, and transitional housing units
- Across 12 pilots, over 190 partner organizations, including housing providers, homeless advocates, social service agencies, behavioral health departments, food banks, and corrections departments, among others, are collaborating to coordinate care for enrollees*
- Pilots increased the number of WPC patients engaged in alcohol and drug treatment, as well as screenings for suicide risk among patients diagnosed with major depression*

Pilot Highlights

**Alameda**
Developed a Social Health Information Exchange, in collaboration with 15 community partners, that includes over 16,000 comprehensive client records

**Contra Costa**
Partnered with local community clinics and hospitals to identify WPC patients and develop shared care plans accessible by the entire care team

**Los Angeles**
Employed hundreds of community health workers trained in motivational interviewing, harm reduction, and cultural humility

**Kern**
Partnered with law enforcement to ensure parolees are connected to a patient-centered medical home for complex needs

**Monterey**
Secured housing units for WPC patients in collaboration with the County Housing Authority and Continuum of Care

**Riverside**
Integrated social and health needs screening and referrals into the jail release workflow

**San Bernardino**
Secured transportation to deliver services and engage hard-to-reach patients in remote areas of the county

**San Francisco**
Expanded navigation centers where chronically homeless individuals can access room and board and intensive case management

**San Joaquin**
Expanded recuperative care so homeless patients can recover in a safe place while receiving case management and connections to housing

**San Mateo**
Expanded access to substance use disorder treatment, including sobering care, medication assisted treatment, detox, and rehabilitation

**Santa Clara**
Opened a peer-staffed psychiatric respite center that offers patients a safe alternative to psychiatric inpatient care

**Ventura**
Developed "one stop" mobile care pods at homeless encampments where patients can take a shower, speak with a case manager, and connect to ongoing care

*Based on available data from CAPH members

www.caph.org  www.safetynetinstitute.org