

WHOLE PERSON CARE

In California's Public Health Care Systems

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.



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.



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.



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.



Sharing Data

WPC funds innovative health information technology that allows different types of providers to communicate and share data in real time.



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.

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