HC HARBAGE CONSULTING

The California Whole Person Care Pilot Program: County Partnerships to Improve the Health of Medi-Cal Beneficiaries

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Introduction

The California Whole Person Care (WPC) Pilot program is designed to coordinate health, behavioral health, and social services in order to improve the health outcomes of Medi-Cal beneficiaries who are high utilizers of the health care system. Through collaboration and coordination among county agencies, health plans, providers, and other entities, the WPC Pilots are designing and developing the infrastructure and processes to integrate and improve care for vulnerable populations.

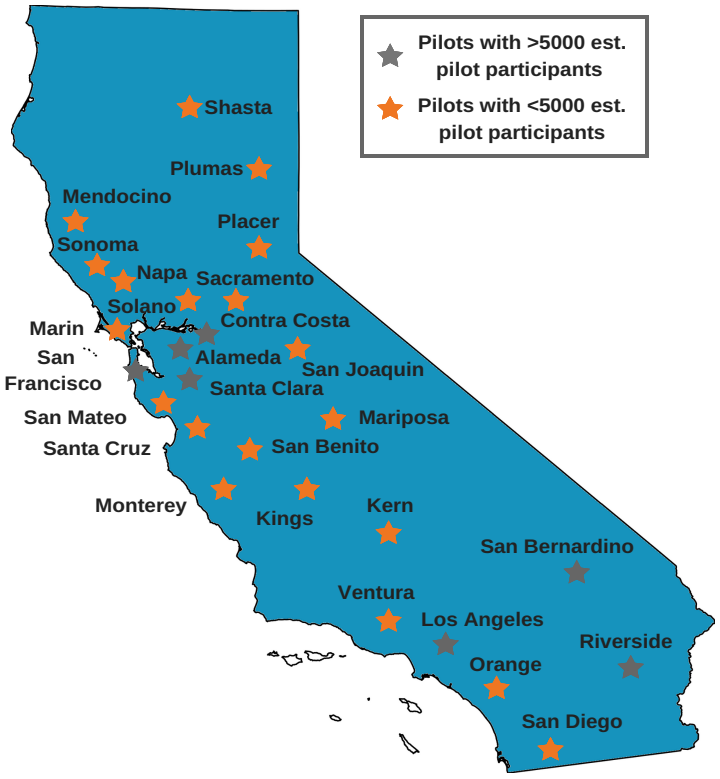
The five-year program, approved in December 2015 as part of the Medi-Cal 2020 waiver, will provide up to $3 billion to support the Pilots – $1.5 billion of federal Medicaid matching funds and $1.5 billion from local funds provided through intergovernmental transfers (IGTs). Reimbursement is not provided for services already covered by Medi-Cal.

Summary of Approved WPC Pilots

To participate in the WPC Pilot program, Pilot lead entities (usually a county government) submitted an application to the Department of Health Care Services (DHCS) that outlined their approach to key design components of the program. While the waiver established minimum standards for participation, applicants had some flexibility to propose strategies that would best meet the needs of their local communities.

In November 2016, DHCS approved 18 WPC Pilot applications (see Appendix A), accounting for nearly $2.4 billion of the $3 billion in total available funding for the WPC Pilot program. Because the state did not allocate all of the available funding in the first round, DHCS opened a second application period in early 2017. The second round of WPC funding was available to entities that did not apply during the first round, as well as Pilots that were approved in the first round that wanted expand their programs. The seven second round WPC pilots were approved in June 2017.

Figure 1: Whole Person Care Pilot Locations and Size



Target Populations

The Medi-Cal 2020 waiver listed populations that WPC Pilots could target but permitted Pilots to identify additional populations in their applications. Figure 2 lists the number of pilots focused on each target population.

Figure 2: WPC Pilot Target

Target Population	# of Pilots
High utilizers with repeated incidents of avoidable Emergency Department (ED) use, hospital admissions, or nursing facility placement	17 Pilots
Individuals who are homeless/at-risk for homelessness	23 Pilots
Individuals with mental health and/or substance use disorder (SUD) conditions	13 Pilots
Individuals recently released from institutions (e.g. hospital, jail, Institutions for Mental Diseases (IMD), skilled nursing facility)	11 Pilots
High utilizers with two or more chronic conditions	8 Pilots
High-risk pregnant mothers	1 pilot
Individuals with a cognitive impairment	1 Pilot

** WPC Pilots may target more than one population.*
*** WPC target populations may have sub-target populations that are not included in the have a graph.*

WPC Pilot Themes

Although the WPC lead entities have flexibility in designing interventions to address local needs, many Pilots share similar elements: 1) Supporting the homeless population; 2) Enhancing care coordination; and 3) Sharing patient data across providers. Below are descriptions of these key themes across the Pilots and highlighted examples of individual WPC Pilot strategies.

Supporting the Homeless Population

Twenty-three WPC Pilots are targeting Medi-Cal beneficiaries who are homeless or at-risk of homelessness, populations that typically have more frequent ED usage and inpatient hospital stays and lack the resources to maintain stable housing. Pilots will support this population by enhancing care coordination efforts and providing a range of housing support services.

Targeted Care Coordination and Wrap-Around Services

The WPC Pilots are providing targeted care coordination and wrap-around services to ensure that homeless beneficiaries receive ongoing care, particularly following acute illnesses and ED visits. The WPC Pilots have innovative plans to provide coordinated and sustainable care for this population. Figure 3 outlines examples of the types of interventions the Pilots are implementing to reduce the effects and occurrence of homelessness.

Figure 3: Examples - WPC Pilot Enhanced Care Coordination and Wrap-Around Services

Intervention	Key Components
Recuperative Care Services	• Short-term residential care for those recovering from an acute illness or injury • Assistance with activities of daily living • Linkages to health, mental health, and substance use disorder services • Coordination with permanent housing providers
Sobering Centers	• Medical triage, wound dressing changes, rehydration service • Bedding during recovery • Linkages to health, mental health, and substance use disorder services
Mobile Teams/Service Integration Teams	• Mobile vans bring teams to meet the beneficiary where they are located • Linkages to health, social, and homeless care support services • Staffed by a variety of providers including: nurse practitioners, behavioral health specialists, substance abuse specialists, probation officers, and others
Peer Support Specialists	• Specialists who model recovery, offer advice on housing, conduct outreach, and connect beneficiaries to case management

Housing Support Interventions

In order to address the ongoing health and housing needs of homeless beneficiaries, many WPC Pilots are implementing programs to connect individuals to sustainable housing. These programs vary, but typically include providing beneficiaries with a variety of housing navigation services including: 1) placing beneficiaries in safe housing; 2) working with landlords to help them manage risks involved with housing the population; and 3) working with both parties to maintain the beneficiary's housing situation once it is established.

A. WPC Pilot Spotlight: Alameda County Health Care Services Agency - Housing-Related Services

Alameda County has a comprehensive plan to help WPC Pilot participants find and maintain stable housing. The table below outlines key components of these services.

Service	Key Components
Housing and Tenancy Sustaining Services	• Assistance identifying safe and affordable housing, linking beneficiaries to permanent housing, and providing move-in assistance (security deposits, furniture, etc.) • Residency retention services including: household management, landlord relations coaching, dispute resolution, housing recertification, linkages to services, and updating housing support and crisis plans
Skilled Nursing Facility Housing Transitions Program	• Intensive housing navigation services for beneficiaries transitioning out of a Skilled Nursing Facility and into more independent community settings
Street Outreach	• Expanded outreach to link unsheltered chronically homeless individuals to care
Community Living Facilities Quality Improvement	• Create a database of existing units, including information on quality and availability • Create and enforce housing standards; certify housing as clean and safe • Provide consultation, education, and training to operators, residents, and the community
Housing Education and Legal Assistance Program	• Create a legal services unit dedicated to housing • Toll-free number for beneficiaries with housing access or retention problems • Housing education workshops

B. WPC Pilot Spotlight: Los Angeles County - Homeless Care Support Services

Los Angeles County is implementing a number of projects focused on helping homeless beneficiaries, including through the Homeless Care Support Services (HCSS) program. HCSS provides beneficiaries with comprehensive wrap-around services to improve their health, achieve housing sustainability, and decrease the use of high-cost services. Beneficiaries are connected to permanent housing opportunities and receive rent subsidies either through Section 8 federal funding or through the county's flexible housing pool funds. The HCSS program provides three levels of services depending on the beneficiary's needs:

Tier 1: Bridge

- Services provided 24 hours a day, seven days a week
- Targeted at beneficiaries who have just come off the streets, are least connected to services, and are most likely to have unmanaged health and behavioral health conditions

Tier 2: High Acuity

- Provided to beneficiaries during their first 12 months in permanent housing.
- Targeted at beneficiaries who have just come off the streets, are least connected to services
- Each Case Manager is assigned to 20 beneficiaries to help them:
  - Obtain identification cards, birth certificates, and other documents
  - Navigate housing identification and procurement processes
  - Develop relationships with health providers
  - Manage their health conditions
  - Learn life skills (e.g. meal prep, personal finances)

Tier 3: Low Acuity

- Provided to beneficiaries after living in permanent housing for 12 months, if evaluated as appropriate
- Each case manager is assigned to 40 beneficiaries
- Moderate case management provided based on beneficiary's need

Enhanced Care Coordination and Care Management

Many WPC Pilots are providing enhanced care coordination and care management services, particularly for beneficiaries with multiple chronic conditions, mental health disorders and/or substance use disorders, and those recently released from an institution (e.g. jail/prison, or Institutions for Mental Diseases).

C. WPC Pilot Spotlight: San Diego County Health and Human Services Agency - Service Integration Teams and Customized Care Management Module

San Diego County is using "Service Integration Teams" (SITs) and advanced information technology (see below) to address and coordinate beneficiaries' housing, health, and social service needs. Each of the twelve SITs includes a social worker and peer support specialist with access to a shared staff of two registered nurses, four housing navigators, and a project manager. The SITS provide services to beneficiaries for up to two years, altering the intensity of services based on beneficiary need.

Enrollment and Service Timeline

Phase	Time Period	Services
1	1-3 months prior to enrollment	Intensive outreach and engagement resulting in enrollment
2	1-3 months after enrollment	Intensive housing navigation, care coordination, and development of Comprehensive Care Plan (CCP)
3	4-9 months after enrollment	Continued care coordination, monitoring of CCP, and housing supports and tenancy sustaining services
4	10-15 months after enrollment	Moderate care coordination
5	16-27 months after enrollment	Lower level care coordination and follow-up

Advanced Information Technology through ConnectWellSD:

- ConnectWellSD links data from nine systems to provide a comprehensive service profile for each beneficiary
- SITs will use a customized care management module in ConnectWellSD to:
  - Enhance data sharing among multiple systems, including health, housing, and social services;
  - Support care coordination; and
  - Receive "real time" information on emergency department visits and hospital admissions via the county's health information exchange, San Diego Health Connect.

The care coordination efforts involve assessing beneficiaries to determine their health, behavioral health, substance use disorder (SUD), and social service needs and developing care plans to guide treatment. Some WPC Pilots are developing care teams of providers and social service representatives to provide comprehensive support. Additionally, some Pilots are tailoring the type and intensity of services based on the needs of target populations (e.g. individuals recently released from incarceration) or according to the beneficiary's progress.

D. WPC Pilot Spotlight: Kern Medical Center- Streamlining Transitions Back into the Community

Kern County is using enhanced care coordination to help beneficiaries recently released from incarceration transition back into the community. Key components include:

- Provision of services up to 90 days following release from incarceration;
- A health care clinic established within the jail to provide beneficiaries who have been presumptively determined eligible for Medi-Cal prior to release with a wellness check, drugs prescribed while incarcerated, and a discharge plan based on a health assessment;
- A post-incarceration liaison is assigned to the care team 90 days after their release;
- Life skills transition classes; and
- Enrollment in ongoing care coordination services.

Enhanced Care Coordination – Behavioral Health

Under the WPC program, many Pilots are implementing projects focused on expanding and increasing access to resources for those with SUDs and behavioral health disorders. Through the use of navigation teams, integration with primary care, and mobile outreach and response teams, Pilots plan to identify, engage, and treat this population in a comprehensive manner.

E. WPC Pilot Spotlight: San Joaquin County Health Care Services Agency- Behavioral Health Navigation Teams

San Joaquin County will use both Navigation Teams and Mobile Crisis Response Teams to ensure that beneficiaries with behavioral health disorders receive timely, appropriate, and comprehensive care.

Role of Navigation Teams

- Help beneficiaries address non-clinical barriers to care (e.g. transportation, housing)
- Develop linkages with community resources
- Collaborate with Mobile Crisis Response Teams
- Link beneficiaries to WPC services including post-crisis follow-up and stabilization
- Work to re-engage beneficiaries who do not follow-up with care
- Provide ongoing support for the duration of individuals' enrollment in the WPC Pilot

Role of Mobile Crisis Response Teams

- Conduct on-site mental health assessments, interventions, and treatment evaluations
- Work to reduce incarceration of beneficiaries who are suffering from a mental health crisis
- Refer beneficiaries to WPC participating entities and community partners

Data Sharing Across Providers

The WPC Pilot program requires Pilots to develop data collection and data sharing capabilities across participating entities, including with their partner managed care plan(s) (MCPs). MCPs will provide the lead entity with basic client information to identify the patient population eligible for the WPC program. MCPs can request information that is available within the data system, such as utilization and enrollment figures and can schedule regular comprehensive reports on services provided.

All 25 Pilots are using the WPC funding to expand their existing data sharing frameworks, with the goal of developing data systems that enable a beneficiary's health care providers, care coordinators, and social service providers to share data and communicate effectively. Below are examples of the types of data projects that are being implemented under the WPC program:

- Health Information Exchanges (HIE)
- Patient population software
- Case management software
- Data warehouses
- Real-time data collection

F. WPC Pilot Spotlight: San Francisco Department of Public Health- Multi-Agency Care Coordination System (MACCS)

The MACCS includes a data sharing platform, a multi-agency universal assessment tool, and enhanced care coordination capabilities. This system will leverage learnings from their current integrated system and expands its reach, depth, and utility to enable the San Francisco Department of Public Health and its partner entities to:

- Establish a data sharing platform that can be used as both a real-time mobile care management tool that links information across city agencies and community-based organizations and an integrated data system for analysis and monitoring
- Develop and implement a multi-agency universal assessment tool to evaluate the needs of each homeless San Franciscan
- Strengthen care coordination by stratifying the population based on risk and prioritizing those with the greatest needs for the most intensive interventions
- Provide a foundation for a citywide navigation system, which will align shelter and housing resources, including wraparound services and create system-wise priorities and data to match people in need with the appropriate housing intervention.

WPC Pilot Payments

Pilots will receive payments from DHCS based on their approved budgets, assuming they achieve the WPC goals and metrics outlined in their approved application. All WPC budgets are required to be deliverables-based.

- In the first year, the WPC Pilots were focused on infrastructure development. Pilots received payment for submitting their applications and reporting baseline data.

- In years two through five, the Pilots are focused on providing services, implementing interventions, achieving metrics, and providing incentive payments. Pilots must submit mid-year and annual reports to DHCS and will receive payment based on achieving the metrics outlined in their application.

Each WPC Pilot lead entity chose the financing structure that will be used to pay for the interventions in their county, including fee-for-service (FFS), per member per month (PMPM) bundles, pay for reporting, pay for outcomes, and incentive-based payments. In most cases, Pilots will use PMPM bundles to pay for care coordination and housing services. Each PMPM is calculated based on the expected cost of a typical beneficiary who will receive services under the Pilot. Pilots typically use a FFS structure for 'one-time' services, such as those provided at sobering centers. Payments for reporting, outcomes, and incentives are designed to encourage the Pilots to achieve the goals of WPC and provide them with funding to support quality improvement activities and data sharing.

Incentive Payments

The WPC Budget guidelines allowed Pilots significant flexibility in developing their budgets, including allowing Pilots to request incentive funding for reporting on metrics and achieving outcomes. Pilots were encouraged to explain in their applications how they would ensure that incentive payments would flow through to downstream providers. Some Pilots chose to place a larger portion of their budgets into meeting self-determined outcomes and will only receive these payments if they achieve the goals established in their application. Smaller Pilots were less likely to take on this risk, often due to the uncertainty of achieving metrics with smaller populations. These smaller Pilots placed more of their budgets into reporting measures, making it more likely they will receive the full payments.

Both Los Angeles County and Santa Clara County developed budgets in which the amount of funding they receive is tied to achieving established outcomes. These systems of payment are designed to hold the counties accountable for achieving the goals outlined in their applications, but also provide incentives for partial achievement, thereby encouraging the Pilots to continue to work toward their goals throughout the duration of the Pilot.

For example:

- **The Los Angeles County Department of Health Care Services** assigned a point total for each milestone incentive payment category in its budget: Timely Implementation, Physical Infrastructure Development, and IT/Quality Infrastructure Development. In order to receive full payment for a given category, the county must earn all of the points assigned to that category. If the county only earns some of the points in a category, they receive a proportionally lower payment for that category.
- **The Santa Clara Valley Health and Hospital System** established a tiered system of outcome measures under which they will receive 100 percent of the incentive payment for fully meeting a given goal, 90 percent of the payment for meeting 90 percent of the goal, phasing down to 10 percent of the payment for meeting 10 percent of a goal.

In order to encourage innovation and quality improvement throughout the duration of the WPC Pilot, DHCS allows Pilots to request annual budget rollovers and adjustments (beginning in program year three) to enable pilots to adjust to challenges and lessons learned during implementation. Rollovers are available on a per Pilot basis based on discussions with DHCS and can result in allowing Pilots with unspent funds to roll those funds over to the next program year. Adjustments can be made by all Pilots on an annual basis and enable pilots to move funds from one category of their budget to another based on need. Neither the rollover process nor the adjustment process allows Pilots to request additional funding.

Round Two Pilots

In June 2017, DHCS approved WPC applications for seven additional Pilots and expansion applications for eight existing pilots, as reflected in Figure 4 below. The new pilots include five individual counties, the only city-sponsored pilot, and a collaborative of three smaller counties. The figures throughout this paper have been updated to reflect the addition of these pilots. Round Two Pilots benefitted from being able to learn from the approved applications of Expansion Pilots. This section highlights a few of the innovative approaches Round Two Pilots plan to implement to address the needs of their target populations.

Figure 4: Round Two Pilots- New and Expansion

Round Two New Pilots	Round Two Expansion Pilots
Kings County	Los Angeles County
Marin County	Monterey County
Mendocino County	Napa County
Sacramento City	Orange County
Santa Cruz County	San Francisco City/County
Small County Collaborative (Mariposa County, Plumas County, San Benito County)	San Joaquin County
Sonoma County	Santa Clara County
----------	Ventura County

G. WPC Round Two Pilot Spotlight: Kings County - KARELink

KARElink, or Kings Area Resource Enhanced Linkages, aims to cut the number of adults with mental illnesses and co-occurring substance use disorders in jail by creating an enrollee-centered system of care and linking enrollees to needed services.

Potential enrollees will be referred to KARELink through health services, law enforcement, the county jail, and community-based organizations. Once referred, they will meet with a **multidisciplinary team (MDT**) that will screen and assess the referee to determine eligibility. The MDT will be comprised of:

- A psychologist
- A registered nurse
- A county eligibility worker
- A housing navigator
- A job developer

The referee will be triaged within 24 hours to determine their level of priority and placed in an appropriate living situation, including: High intensity mental health respite (highest level of need), crisis residential, medical respite, residential treatment, transitional housing, short term recuperative care unit, or in-home placement.

H. WPC Round Two Pilot Spotlight: Santa Cruz - Cruz To Health

Like many Pilots, Cruz To Health is using a **multidisciplinary care team** to address the needs of its target population- individuals with co-morbid behavioral health and physical health conditions and homeless or at risk of being homeless. Unique to Cruz To Health, however, is their inclusion of team members that provide enrollees with:

- Cognitive behavioral therapy;
- Dialectical behavioral therapy;
- Motivational interviewing; and
- Occupational therapy.

Additionally, the program provides training to family members and members of the care team in Evidence Based Practice Cognitive Behavioral Therapy for Psychosis to help them identify issues needing the attention of the care team.

I. WPC Expansion Pilot Spotlight: San Francisco's Resource Center and Coordinated Entry

In its expansion application, San Francisco proposed using a **24/7 Resource Center** to provide respite and service connection to the city's homeless population. The center will provide access to: restroom facilities, showers, enrollment into the county benefit program, and, by leveraging WPC funding, care coordination services and access to social workers.

When homeless residents enter the resource center, they will be triaged and assessed before being entered into **Coordinated Entry** where they will receive help in making connections to medical and behavioral health services. Once in Coordinated Entry, individuals will also be connected to housing navigators and other service providers for housing prioritization and placement.

San Francisco also included **Rapid Targeted Coordination and Navigation Team Services and Enhanced Housing Transition Services** in their expansion application, demonstrating its focus on addressing the needs of the city's homeless population.

Going Forward

Both Legacy Pilots and Round Two Pilots are in the implementation phase of their pilots and enrolling beneficiaries into their programs. However, due to the innovative nature of the WPC program, the Pilots' initial proposals are subject to change. With the upcoming implementation of the Health Homes Program in California, for example, Pilots will need to make changes to their programs to ensure no duplication of Health Homes services for Health Home eligible populations. Additionally, as Pilots run into implementation challenges, they may need to make adjustments to their original plans, with approval from DHCS.

DHCS continues to work closely with Pilots to implement these innovative programs through on-going technical assistance and a pilot-wide learning collaborative. The learning collaborative tracks the implementation issues the Pilots are facing and encourages shared learning through pilot-wide and pilot-specific calls, topic-specific webinars and affinity groups, twice-yearly in-person meetings with all of the pilots, and other evolving strategies, based on the needs of the Pilots.

Ultimately, the goal of the WPC Program is to provide comprehensive, effective and efficient health care and social services support to improve the health and well-being of vulnerable Medi-Cal beneficiaries. The WPC Programs use of targeted efforts, autonomy and innovation can serve as model for other states that are looking to incorporate community and social services to provide comprehensive support for their Medicaid beneficiaries.

Appendix A: Summary of Approved WPC Pilots

WPC Lead Entity	Target Population(s)	Estimated Number of Beneficiaries	Five-Year Budget
Alameda County Health Care Services Agency	• Homeless, at risk of homelessness • High-risk, high-utilizers • Medically complex	20,000	$283,453,400

City of Sacramento	• Homelessness, at risk of homelessness with emphasis on:
	  ○ High utilizers
	  ○ SMI and/or SUD
	  ○ Chronic physical health conditions
		4,386	$64,078,680

Contra Costa Health Services	• High-risk, high-utilizers ○ *includes homeless, at risk of homelessness	52,500	$203,958,160

County of Marin, Department of Health and Human Services	• Homeless, at risk of homelessness following release from institutions
	• Complex medical conditions
	  ○ Repeated avoidable ED use, hospital admissions, nursing facility placement
	  ○ Two or more chronic conditions
	  ○ SMI and/or SUD
		4,054	$20,000,000

County of Orange, Health Care Agency	• High-risk, high-utilizers and homeless, at-risk of homelessness • SMI	9,303	31,066,860

County of San Diego County Health and Human Services Agency	• High-risk, high-utilizers and:
	  ○ Homeless, at risk of homelessness
	  ○ SMI, SUDs, or chronic physical health conditions
		1,049	$43,619,950

County of Santa Cruz, Health Services Agency	• High utilizers • Two or more chronic conditions • SMI and/or SUD • Homeless, at risk of homelessness • Justice involved	625	20,892,336
County of Sonoma, Department of Health Services, Behavioral Health Division	• Homeless, at risk of homelessness with an SMI diagnosis and one or more of the following: ○ Co-Occurring health conditions	3,040	$16,704,136

WPC Lead Entity	Target Population(s)	Estimated Number of Beneficiaries	Five-Year Budget
	(including SUD) ○ High-utilizers of ED ○ Served by multiple agencies		
Kern Medical Center	• High-risk, high-utilizers with emphasis on: ○ Homeless, at risk of homelessness ○ Release from incarceration	2,000	$157,346,500
Kings County	• High utilizers of public systems with one or more of the following: ○ SMI and/or SUD ○ Chronic illness (hypertension and diabetes) • 5/6 expected enrollees are expected to be justice impacted	600	$12,848,360
Los Angeles County Department of Health Services	• Homeless, at risk of homelessness • Justice-involved High Risk • SMI and/or SUD • High-risk, high-utilizers • Perinatal high risk	370,000	$1,260,352,362
Mendocino County Health and Human Services Agency	• SMI with focus on; ○ High utilizers of mental health and/or medical services ○ Homeless, at risk of homelessness ○ Co-occurring SUD ○ Justice involved	600	$10,804,720
Monterey County Health Department	• High-risk, high-utilizers and homeless, at risk of homelessness and two or more of the following: ○ SMI and/or SUD ○ Two or more chronic conditions ○ Two or more Mental Health Unit admissions ○ Two or more Emergency Department (ED) visits in six months ○ One or more hospital admissions in 12 months ○ Two or more prescribed medications	500	$34,035,672

WPC Lead Entity	Target Population(s)	Estimated Number of Beneficiaries	Five-Year Budget

Napa County	• Homeless, at risk of homelessness with emphasis on:
	  ○ High-risk, high-utilizers
	  ○ Physical disability
	  ○ SMI and/or SUD
	  ○ Multiple chronic conditions
		800	$22,921,433

Placer County Health and Human Services Department	• High-risk, high-utilizers • SMI and/or SUD • Two or more chronic health conditions • Recent release from incarceration • Homeless, at risk of homelessness	450	$20,126,290

Riverside University Health System- Behavioral Health	• Recent release from incarceration, with a focus on:
	  ○ Those on probation for at least one year
	  ○ Homeless, at risk of homelessness
	  ○ SMI and/or SUD
	  ○ Physical health diagnosis
		38,000	$35,386,995

San Bernardino County Arrowhead Regional Medical Center	• High-risk, high-utilizers	2,000	$24,537,000
San Francisco Department of Public Health	• Homeless, at risk homelessness with emphasis on: ○ High-risk, high-utilizers	16, 954	161,750,000
San Joaquin County Health Care Services Agency	• High-risk, high-utilizers • SMI and/or SUD • Homeless, at risk of homelessness upon discharge from an institution	2255	$18,365,004

San Mateo County Health System	• High-risk, high-utilizers with four or more ED visits in the past year. Emphasis on:
	  ○ SMI and/or SUD
	  ○ Homelessness, at risk homeless
	  ○ Recent release from incarceration
		5,000	$165,367,710

Santa Clara Valley Health and Hospital System	• High-risk, high-utilizers and:
	  ○ Engaged in two or more systems of care
	  ○ In the top 5% of utilizers in the health system in the past year
	  ○ *includes those recently released from incarceration and/or are
		10,000	250,191,859

WPC Lead Entity	Target Population(s)	Estimated Number of Beneficiaries	Five-Year Budget
	homeless, at risk of homelessness		
Shasta County Health and Human Services Agency	• Homeless, at risk of homelessness and: ○ Two or more ED visits in the last three months	600	$19,403,550
Small County WPC Collaborative	**Mariposa**: • SMI and/or SUD and one or more of the following: ○ High utilizers ○ Two or more chronic conditions ○ Homeless or at risk of homelessness ○ Justice involved	100	$10,362,176
	Plumas: • SMI and/or SUD and one or more of the following: ○ High utilizers ○ Two or more chronic conditions ○ Justice involved ○ Homeless or at risk of homelessness	140	
	San Benito: • Homeless or at risk for homelessness ○ SMI and/or SUD ○ High utilizers ○ Two or more chronic conditions • Justice involved	187	
Solano County Health & Social Services	• High-Risk, high utilizers and: ○ Avoidable ED use ○ Two or more chronic conditions, with at least one SMI or SUD diagnosis ○ *Includes homeless, at risk of homelessness	250	$4,667,010
Ventura County Health Care Agency	• High-risk, high utilizers including homeless, at risk of homelessness	2,000	$107,759,837