

**From:** [Doreen Bradshaw](#)  
**To:** [Marc Dadigan](#)  
**Cc:** [Donnell Ewert](#); [Dominic De Lello](#); [Katie Cassidy](#)  
**Subject:** Whole Person Care Report  
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**Attachments:** [image002.png](#)  
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Attached is a Whole Person Care report Katie Cassidy provided to our SHARC Integrated Care committee on March 5, 2019. In 2016, Shasta County was selected to be one of a small group of pilot projects throughout California. The Whole Person Care Pilot explores ways to:

- help health care systems work better together,
- deliver services to vulnerable people that address their complex medical, behavioral health and other needs (such as housing).

In Shasta County, this program helps Partnership Health Plan members who are homeless or at risk of homelessness. They must have visited the emergency department at least two times or been hospitalized once in the last three months. People may have one or more of these issues as well: a diagnosed serious mental illness, a diagnosis of substance use disorders (SUD), or an undiagnosed opioid addiction.

When somebody is eligible for Whole Person Care they are connected with a small team made up of a housing case manager, a medical case manager and a Registered Nurse. This "teamlet" works closely with the participant to create a Comprehensive Care Plan. This plan guides efforts to get or keep housing and the highest possible levels of physical, mental and social wellbeing. The Whole Person Care Pilot is a collaborative effort between Shasta County Health and Human Services, Shasta Community Health Center, Hill Country Health and Wellness Center and Partnership Health Plan.

The vision for the Shasta County Whole Person Care Pilot is that each participant:

- Is connected to their medical provider
- Has support in accessing medical and social non-medical services
- Has health needs and chronic conditions that are stabilized through access to medical care
- Has access to substance use treatment services (outpatient and residential) that support their goals
- Has stable housing that supports their behavioral and physical health, through local housing case managers and housing assistance programs working together

Some interesting tidbits from the report:

1. 68% of participants are over the age 50;
2. High prevalence of un/undertreated chronic conditions such as COPD, diabetes, hypertension, cardiac and renal diseases;
3. 51% of participants have established permanent housing; and,
4. Most of the participants are helped with finding temporary shelter or sober living.

Kind of sounds like a precursor to the navigation center. Might be useful in communicating why we need the navigation center and some of the results to support it.

Doreen Bradshaw, Executive Director  
Health Alliance of Northern California  
2280 Benton Drive, Building C, Suite C  
Redding, CA 96003  
P-530-247-1560 x101  
F-530-247-1561

Visit our web-site at [www.thehanc.org](http://www.thehanc.org).

