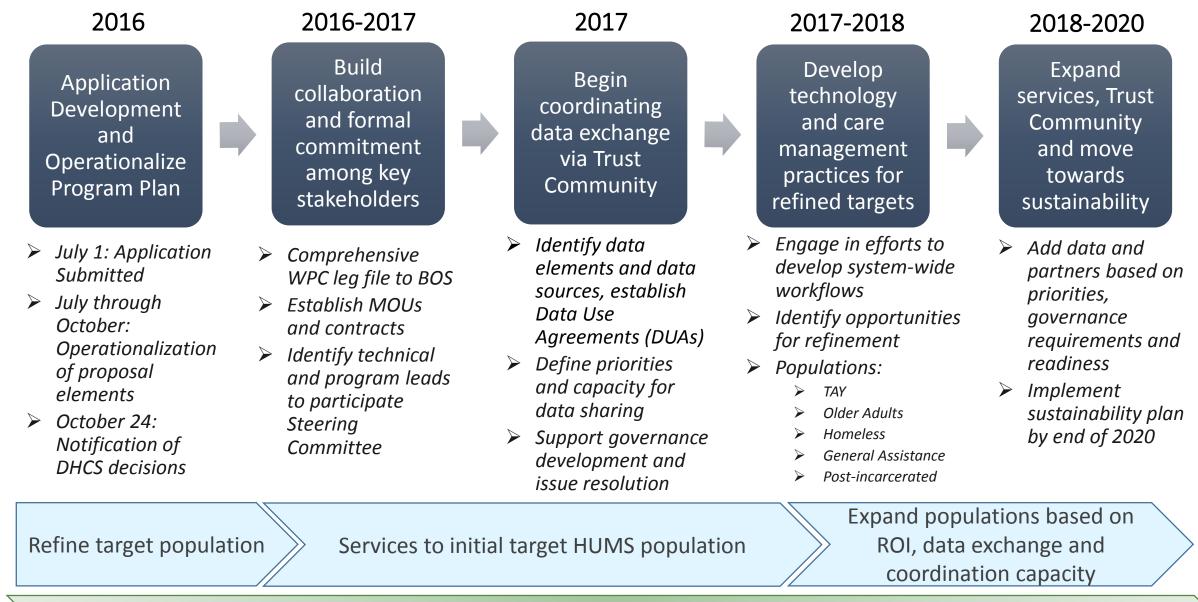
SCVHHS Whole Person Care Logic Model

Inputs	Activities	Outputs	Determinants (Intermediate Outcomes)	Behaviors (Intermediate Outcomes)		ong-Term Outcomes
Plan-Do-Study-Act (PDSA) cycles to assess effectiveness, refine model, achieve continual improvements						
 Providers (VMC, CHP, BHCA) Health Plans (VHP, SCFHP, Anthem) Local hospitals 	Screening and Assessment Existing Medi-Cal Services (Not covered by WPC funds)	Continued Medi-Cal services, in coordination with WPC enhanced coordination	Increased provider and patient knowledge of Medi-Cal and WPC services available	Increased utilization of meaningful, planned care and services	-	
 Information Systems Centers for Population Health Improvement (CPHI) IT leads from participating 	Develop Data Infrastructure via secure Trust Community	Participating Entities share WPC enrolled participants' data (approximately 10,000 participants over five years) for better patient identification and care coordination	Increased real-time shared data; Increased communication between care providers	Improved, seamless experience for participants (clear set of roles and services by team providing care)		mprove Overall Health
entities Clinicians Recovery Coaches 	Start-Up Funding to Fill Service Gaps (launch funding)	Launch and move to Medi-Cal funding of: • Open Sobering center (cap: 20 beds) • Expand Integrated Medical- Psychiatric Skilled Nursing Facility (cap: 60 beds)	Increased capacity of appropriate settings for participants with AOD or concurrent med/psych needs	Decreased avoidable use of Emergency Department / Emergency Psychiatric Services Utilization / Jail	→ I	Reduce Cost of Care
 Clinicians Psychologists Outreach/Peer Workers Health Educators/Coaches 	Expansion of Psycho-Social Support Services	 Wellness/Health Promotion (cap: PY3 1250, PY4 2500, PY5 3750) Medical Respite (cap: 20 beds) Peer Respite (cap: 20 beds) General Assistance Flexible Housing Pool (via savings) 	Increased early detection of risks; Increased supports; Improved self- efficacy to acquire services; Increased knowledge of healthier habits	Increased patient satisfaction, engagement and ownership of their own care plan	_	Decrease Health isparities
 Clinicians Case Managers Social Workers Public Health Nurses 	Expansion of evidence- informed coordinated care management; development of screening and assessment tools	 Enhanced patient engagement to enroll in care management: Short-Term (cap: 250 slots) Mid-Term (cap: 500 slots) Long-Term (cap: 750 slots) 	Enhanced care experience; Reduced duplication of care; Increased support around participants' unique needs	Increased use of appropriate and preventative services with PCPs, case managers, etc.; Reduced readmissions	-	

*WPC runs by calendar year; PY1 = 2016, PY2 = 2017, PY3 = 2018, PY4 = 2019, PY5 = 2020

SCVHHS Whole Person Care Pilot Program Timeline



Plan-Do-Study-Act (PDSA) cycles to assess effectiveness, refine model, achieve continual improvements