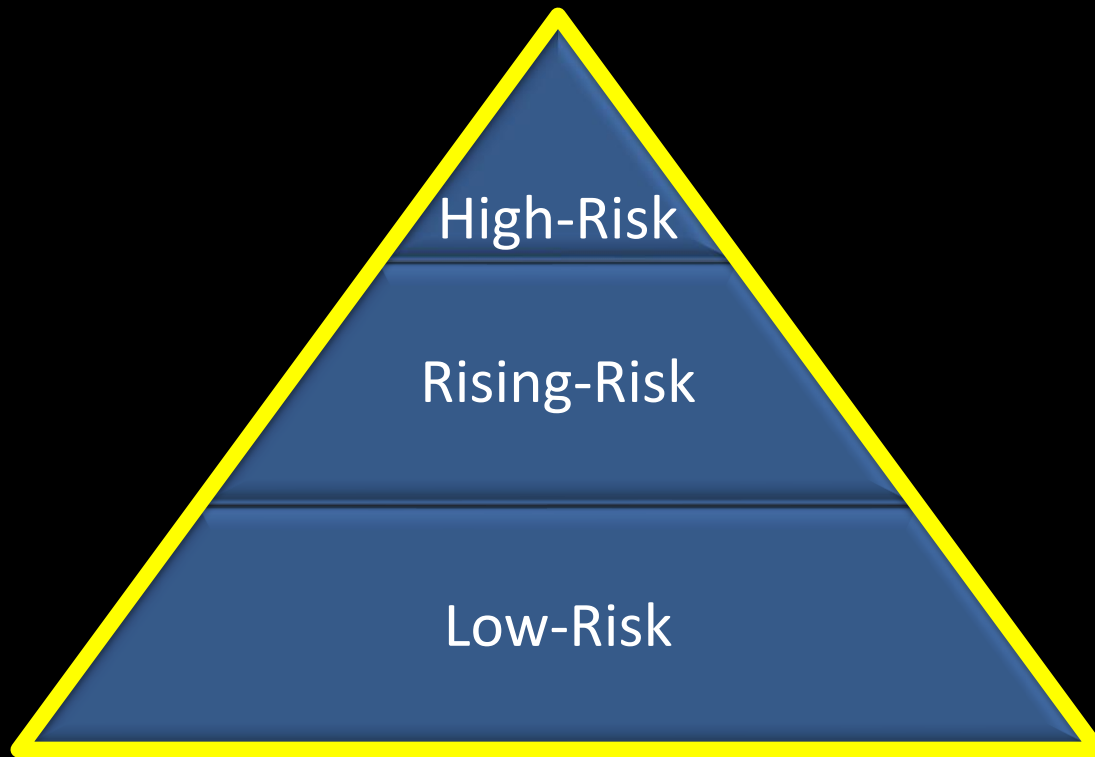


Getting to  
Whole Person Care  
- What's Next?

ITUP LA Health Collaborative  
July 28, 2019

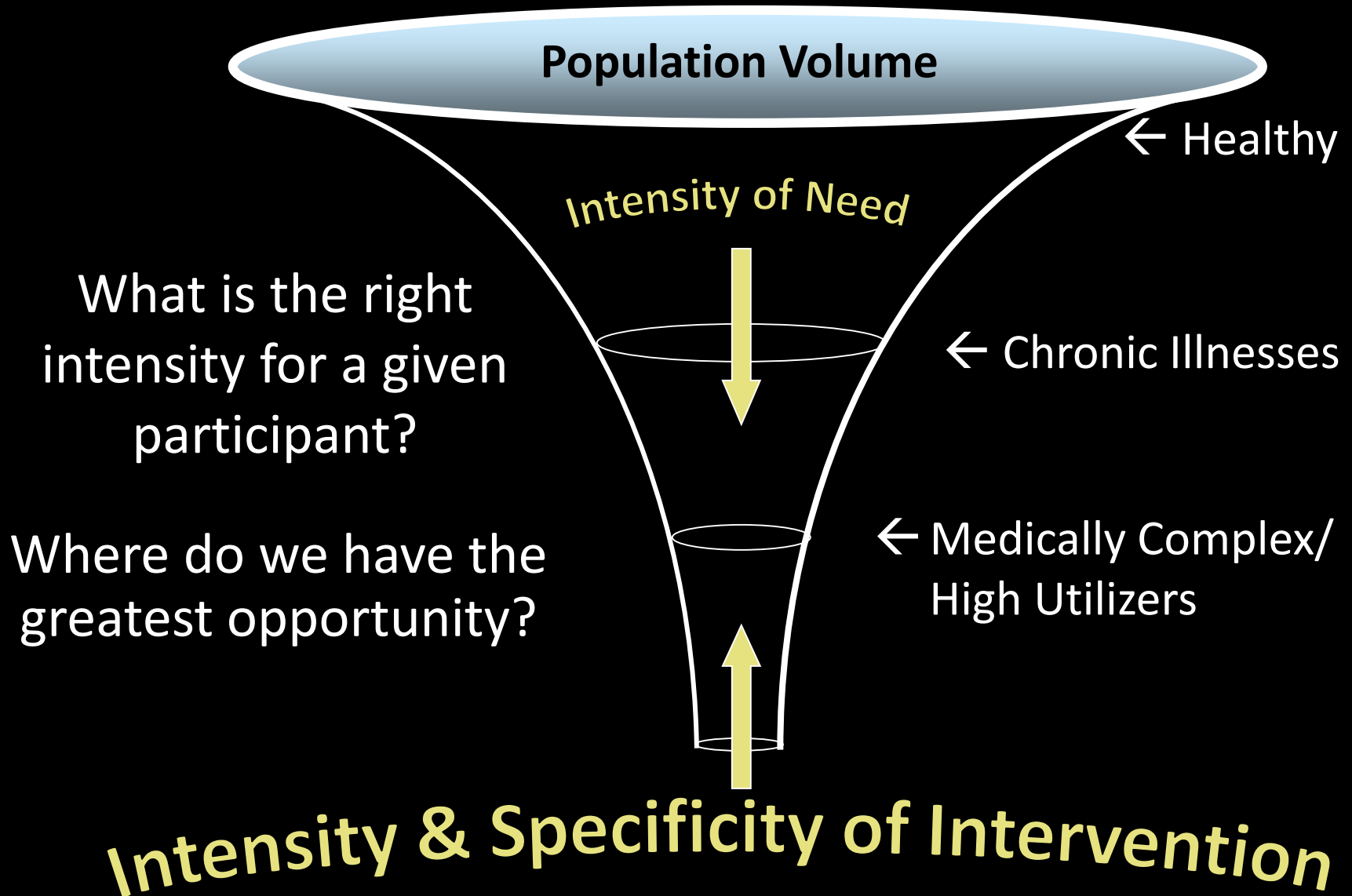
# Important concepts for Care Management

- Build strong relationships with participants, primary care teams, hospitals/specialists & other community care partners
- Align population, intervention(s) & outcomes
  - Select a population at risk for future poor outcomes & costs for which planned interventions can improve outcomes
  - Understand your resources/strengths & that of your engaged partners
  - Match intensity of intervention with intensity of need



**POPULATION HEALTH**

# Effective Targeting of Care Management

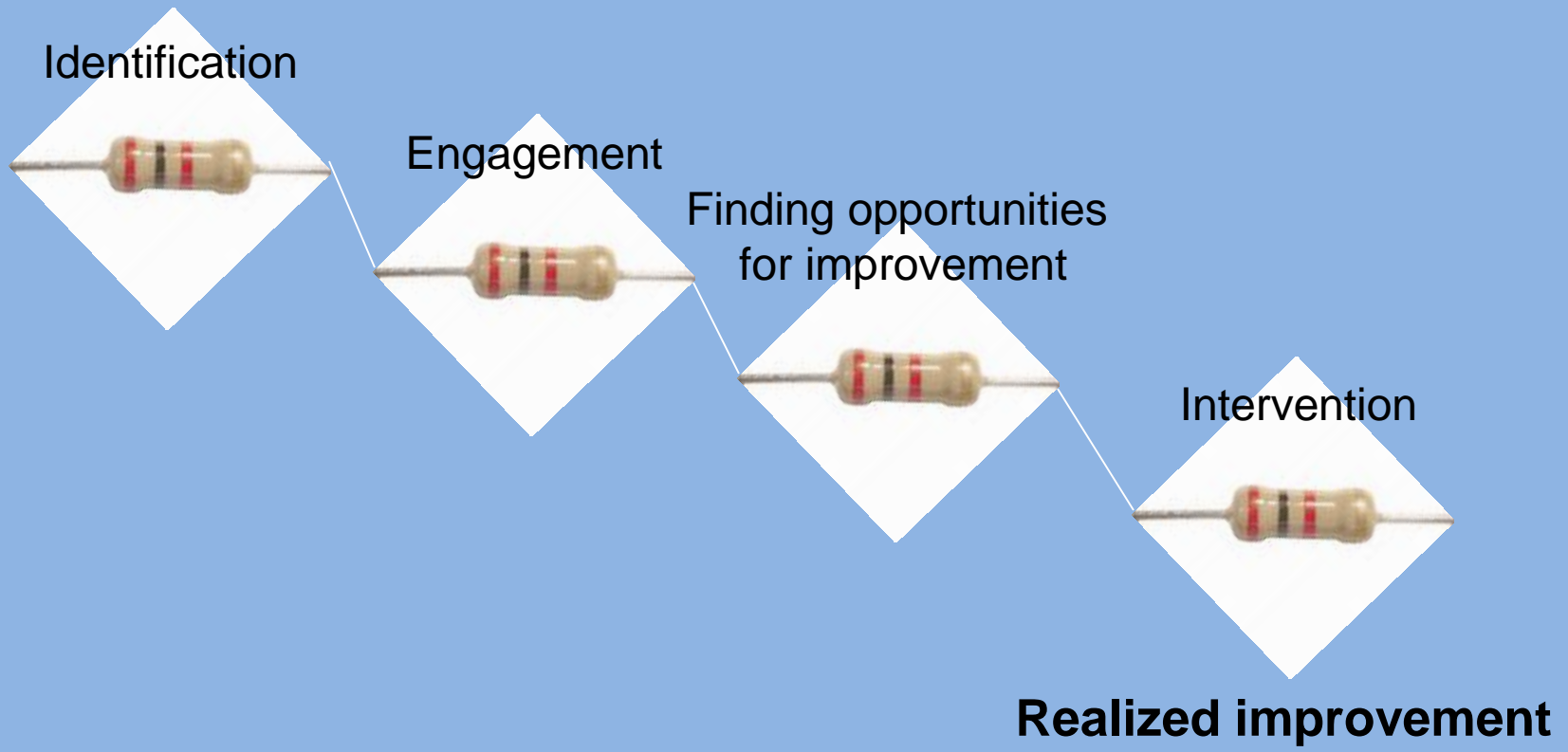




**HIGH-INTENSITY, COMPLEX CARE MANAGEMENT**  
– REQUIRES INTERVENTION ON SOCIAL & BEHAVIORAL  
DETERMINANTS OF HEALTH IN MEDICAID POPULATIONS

# Challenges for CM Programs: Drops in Potential

## Potential opportunity



Adapted from J Eisenberg *JAMA*. 2000

# Whole Person Care-Los Angeles Program Foci

## Integrated Health Delivery

Healthcare & social service coordination enabled by IT/relationships



## Community Health Workers (CHWs)

Social service teams driven by CHWs with shared lived experience



## Regional Care Management

Regional teams applying a “no wrong door” approach

## Transitional Care Coordination

Focus on high-risk times & linkage to & integration with longitudinal providers



# WPC-LA Care Delivery Model

- WPC-LA Care Teams consist of Supervising Social Worker & CHWs in Regional Coordinating Centers in each SPA
- Care Teams
  - Receive referrals from different points of care
  - Engage & enroll participants
  - Perform comprehensive needs survey
  - Create care plan
  - Accompany & help link participants to resources
  - Work closely with participant's longitudinal care team to ensure coordination of care
  - Ensure a seamless handoff to their primary health care team for ongoing care & support





# Populations & Programs

WPC-LA

## Homeless High-Risk

Homeless Care Support Service

Tenancy Support Services

Recuperative Care

Sobering Center

Board & Care Incentive Program

## Justice-Involved High-Risk

Re-entry Enhanced Care Coordination

Community-based Re-entry

Juvenile Aftercare

Sheriff Mental Evaluation Team

## Mental Health High-Risk

Intensive Service Recipients

\*Kin Through Peer

Residential and Bridging Care

Enhanced Care Coordination

## Perinatal High-Risk

Mama's Neighborhood

Benefits Advocacy

## SUD High-Risk

Engagement, Navigation & Support

Naloxone Distribution & MAT Program

Other Services

\*Medical Legal Partnership

## Medical High-Risk

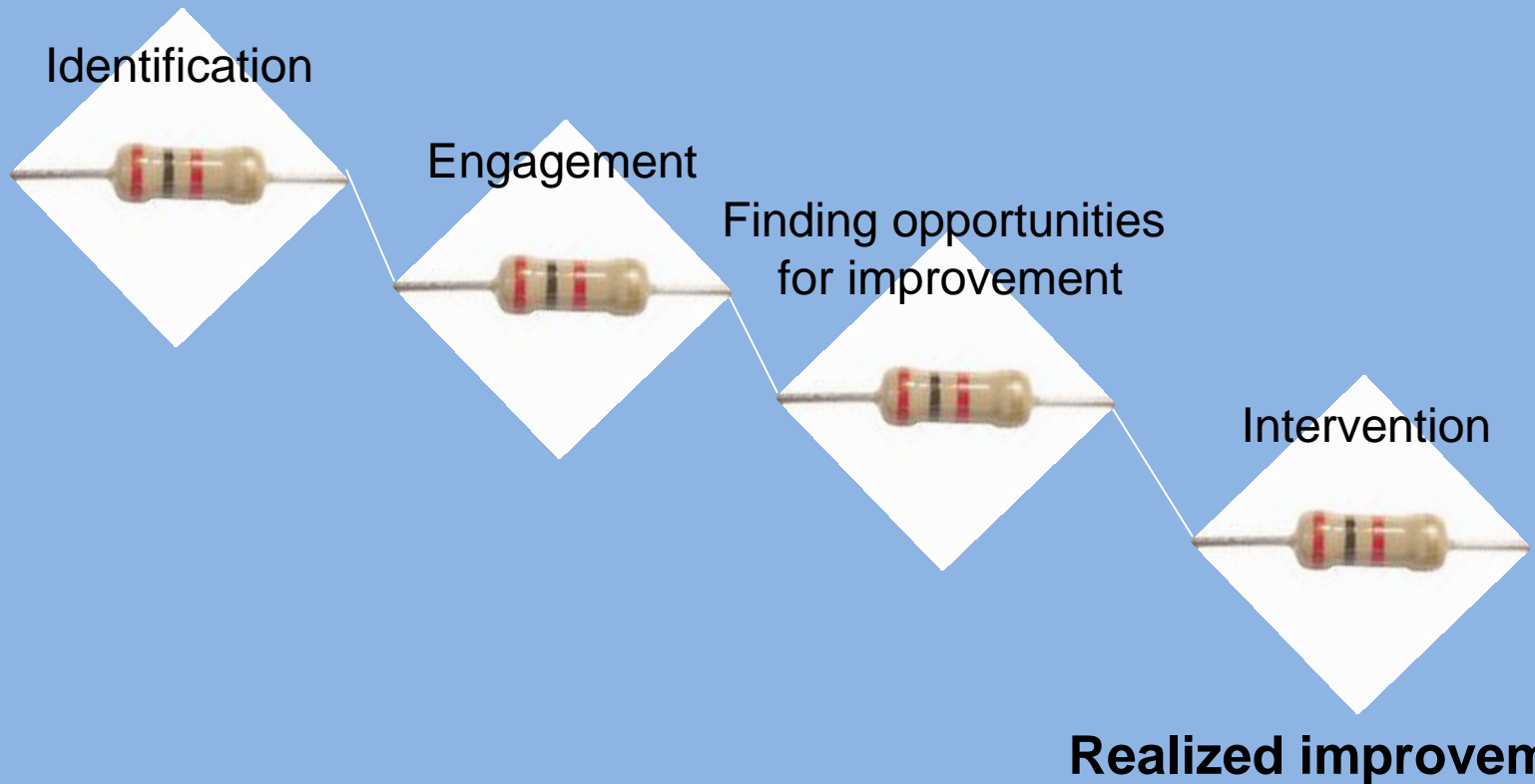
Transitions of Care

Post-Acute Care Transitions

Outreach & Engagement

# Challenges for CM Programs: Drops in Potential

## Potential opportunity



Adapted from J Eisenberg *JAMA*. 2000

# State-Level Roadmap to Higher-performing Health Delivery

Creative Funding –  
expansion,  
braiding/blending

Investment in  
communities &  
community health  
interventions



**Getting to  
Whole Person  
Care  
- What's Next?**

May need special  
models for special  
groups

Focus on both care  
coordination &  
health delivery  
improvement

Capacity Building &  
Infrastructure Building



## Discussion & Questions

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