THE UCLA CENTER FOR HEALTH POLICY RESEARCH

"Whole Person Care Improves Care Coordination for Many Californians"

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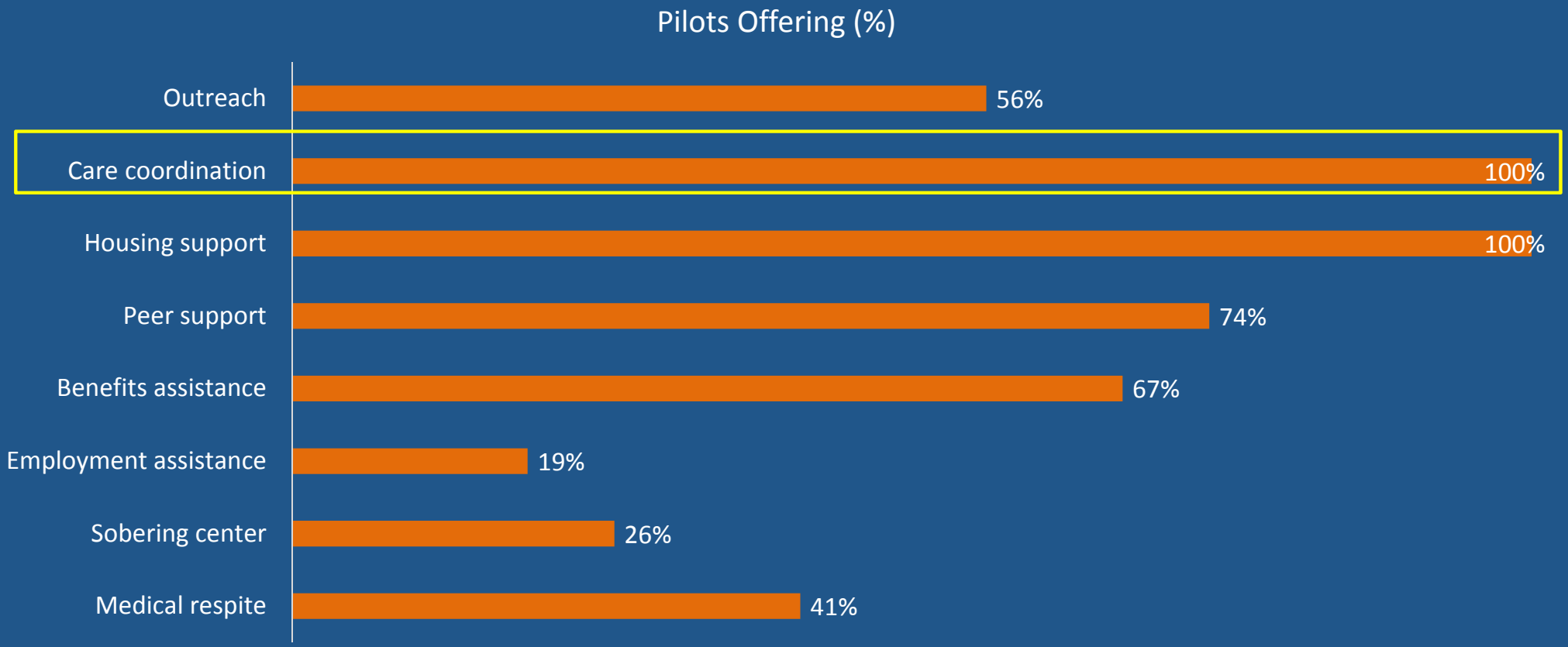
Whole Person Care (WPC) Pilot Program

- Goals: improve the health and well-being of high-risk, high-utilizing enrollees by coordinating care across spheres of care delivery
- Target Populations: High utilizers of ED, hospitals, or SNF; have two or more chronic physical conditions, have SMI/SUD; experiencing homelessness; at-risk-of-homelessness; recently incarcerated
- Pilots: 25 WPC Pilots from 25 counties and 1 city
  - partnerships of county agencies, managed care plans, hospitals, and community providers, often led by the county health agency
  - Approved 5-year budgets ranged from $4,667,010 (Solano County) to $1,260,352,362 (Los Angeles County)
  - Projected 5-year enrollment ranged from 250 (Solano County) to 154,044 (Los Angeles County)

WPC Services



Source: *WPC Applications, Narrative Reports, and Interviews with Lead Entities.*

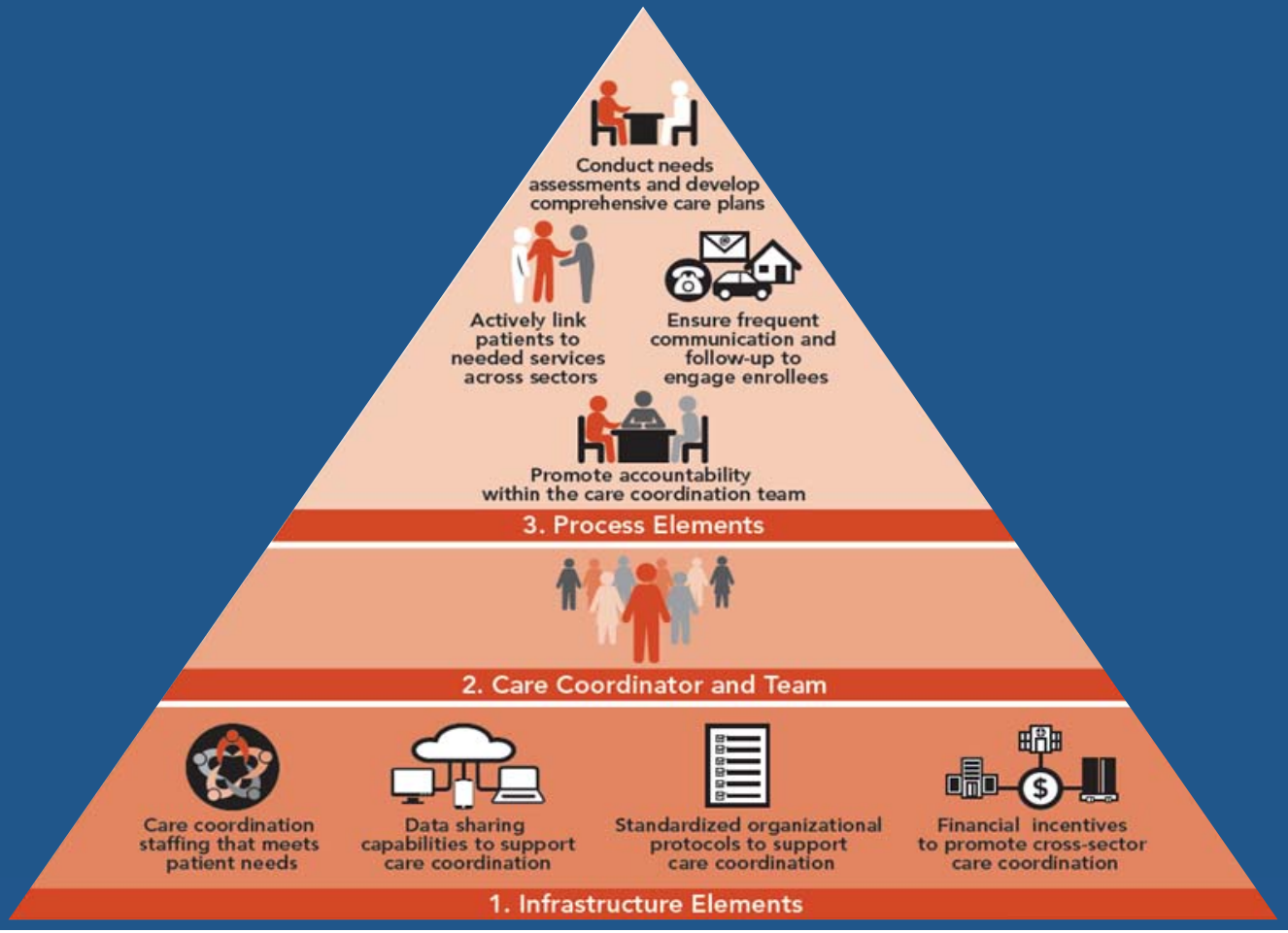
Defining Care Coordination in WPC

"Deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."

–Agency for Healthcare Research & Quality

What specific elements are needed for effective cross-sector coordination of care?

Cross-Sector Care Coordination Framework: Eight Key Elements



Care Coordination: Infrastructure

Financial incentives that may facilitate organizational buy-in and promote accountability for cross-sector care coordination

- Use of risk-stratified payment mechanisms
- Incentive payments linked to performance

Financial Incentives for Care Coordination

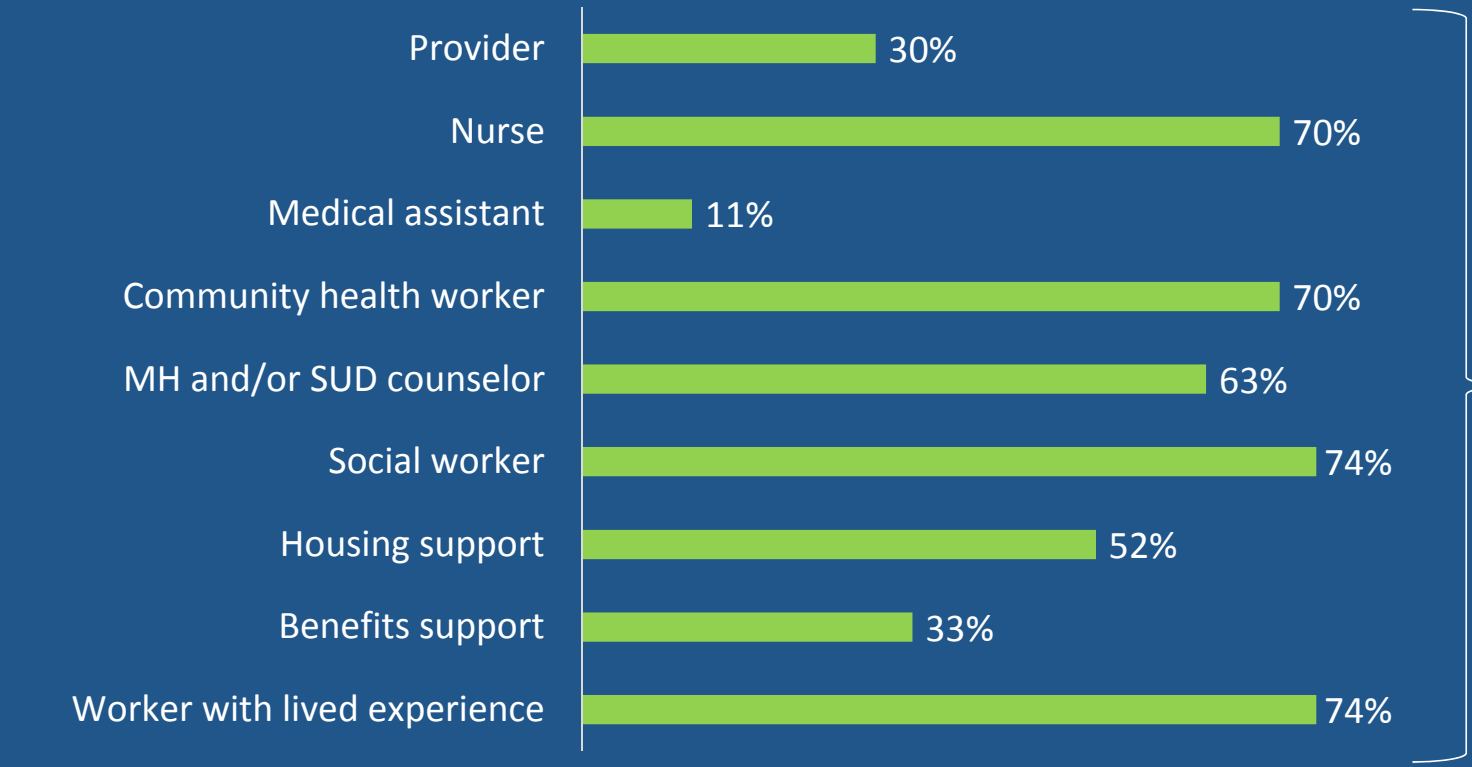
- All Pilots reimbursed for care coordination using capitated per-member per-month (PMPM) payments for a bundle of services
  - 11 Pilots stratified their PMPM bundles based on enrollee risk and tailored service intensity accordingly
- 19 Pilots contracted out some or all care coordination services
  - 14 Pilots indicated that these contracts included financial incentives linked to achievement of specific outcomes

Care Coordination: Infrastructure

Staff must have the capacity to effectively engage with patients that have a wide range of needs.

- Multidisciplinary team with relevant clinical experience
- Inclusion of peers with lived experience to build trust
- Staff workload allows for sufficient availability to effectively engage with enrollees

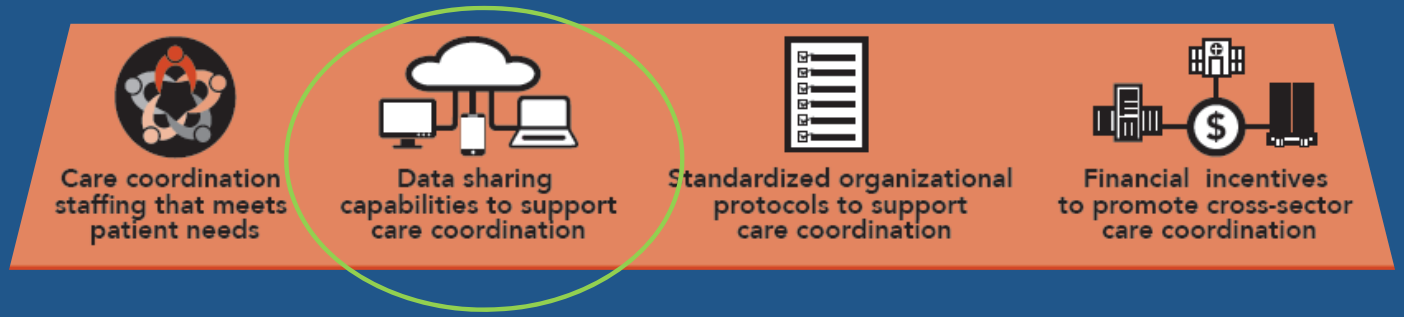
Care Coordination Staffing: Multidisciplinary Care Team Composition



Care coordination services typically provided by non-clinical staff but all teams included at least some staff with clinical experience

Source: *WPC Interviews with Lead Entities and Frontline Staff.*

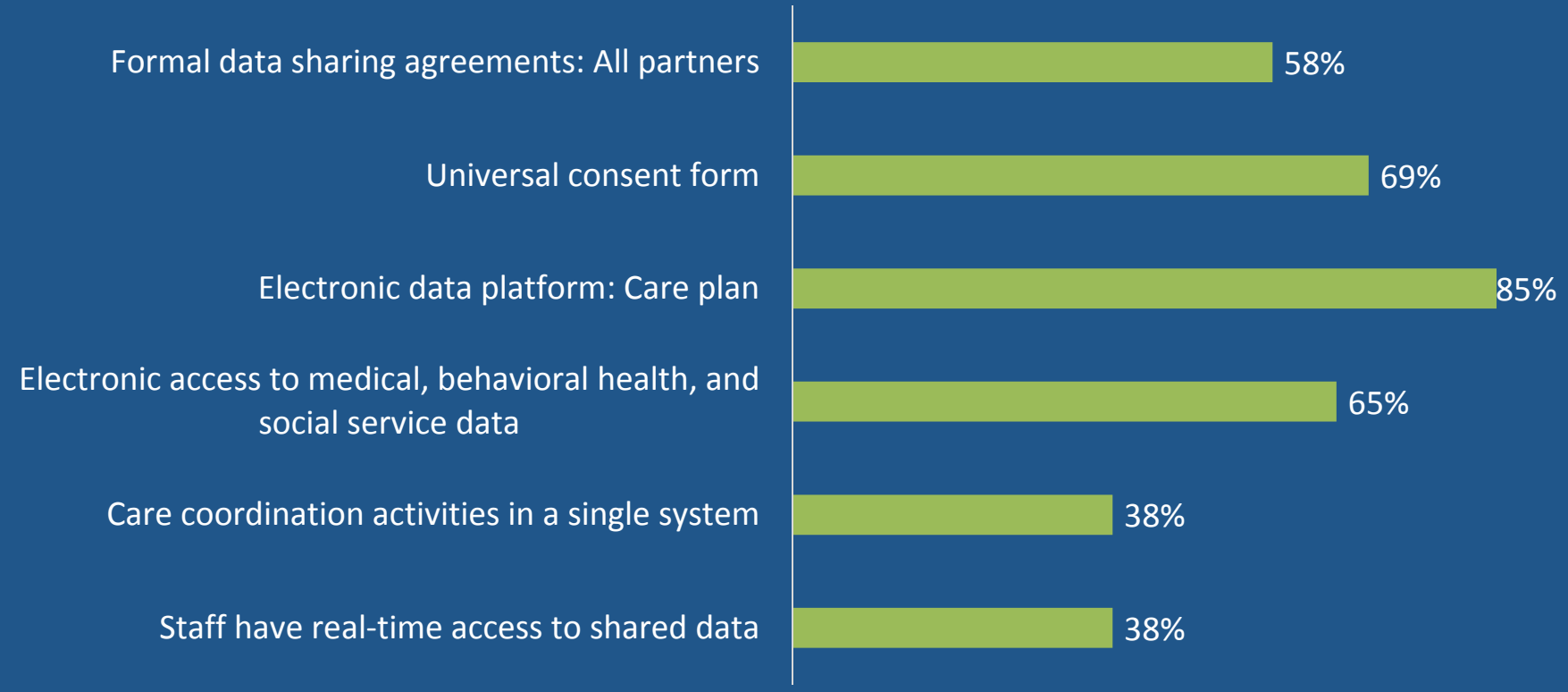
Care Coordination: Infrastructure



Data sharing infrastructure that can support timely sharing of information with all relevant stakeholders, e.g.,

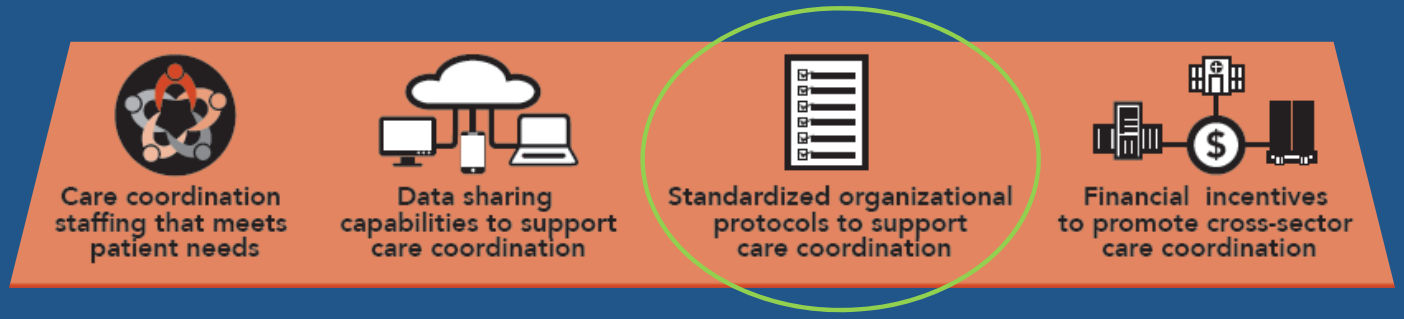
- Formal agreements to define terms and conditions (BAAs, MOUs)
- Universal consent form (can be segmented)
- Electronic data sharing platform

Data Sharing Infrastructure



Source: *WPC Interviews with Lead Entities and Frontline Staff.*

Care Coordination: Infrastructure



Clear organizational protocols that minimize undesirable variation in delivery of care coordination services

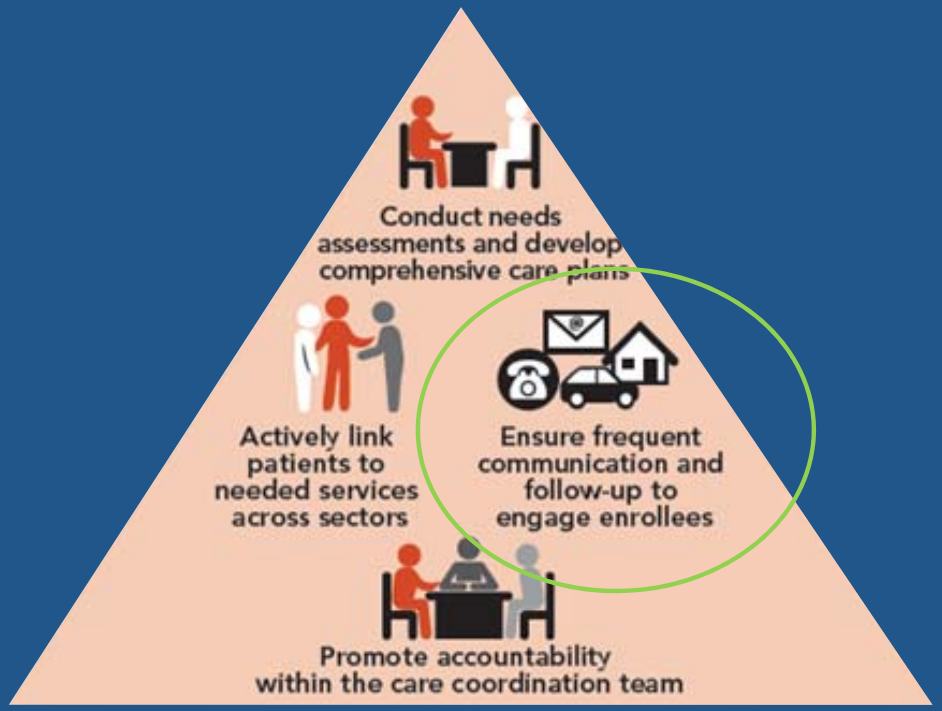
- Procedures for referring patients to needed services
- Procedures for monitoring receipt of services and/or tracking outcomes

Care Coordination Protocols

Most Pilots developed standardized protocols for:

- Referring enrollees to needed services (62%)
- Monitoring and following up on care coordination activities (65%)

Care Coordination: Processes



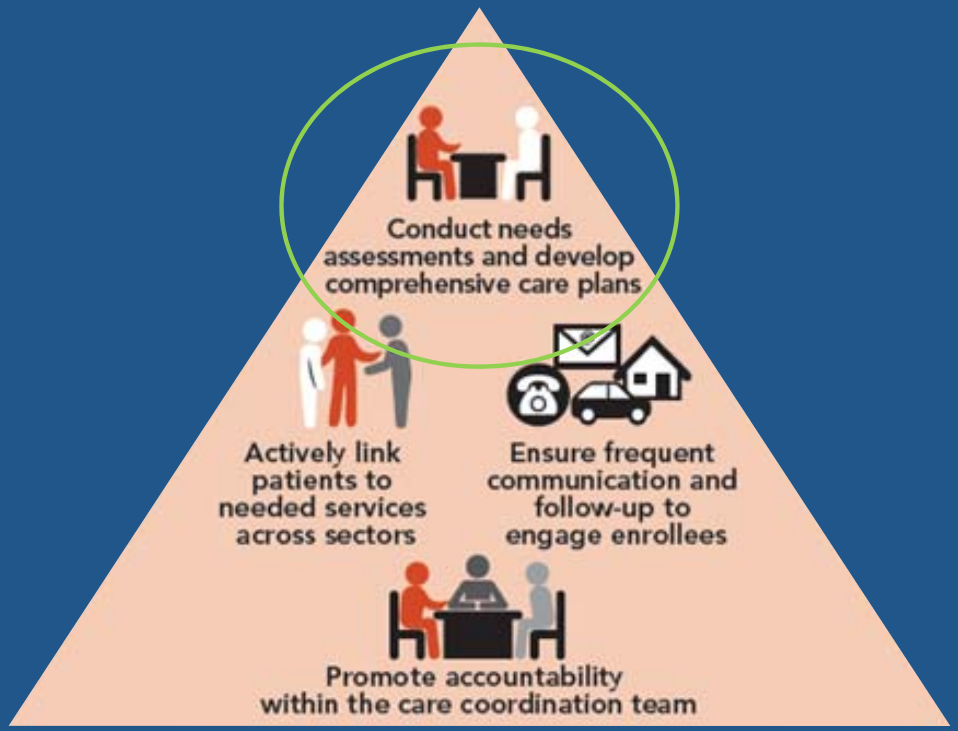
Patient-centered communication strategies to effectively engage enrollees

- In-person
- In the field
- More than once per month

Patient-Centered Communication

- All Pilots included at least some field-based outreach
- Care coordinators in all Pilots reported contacting enrollees more frequently than once per month
- Field-based outreach was described as particularly important for identifying and engaging previously hidden populations and/or homeless enrollees

Care Coordination: Processes



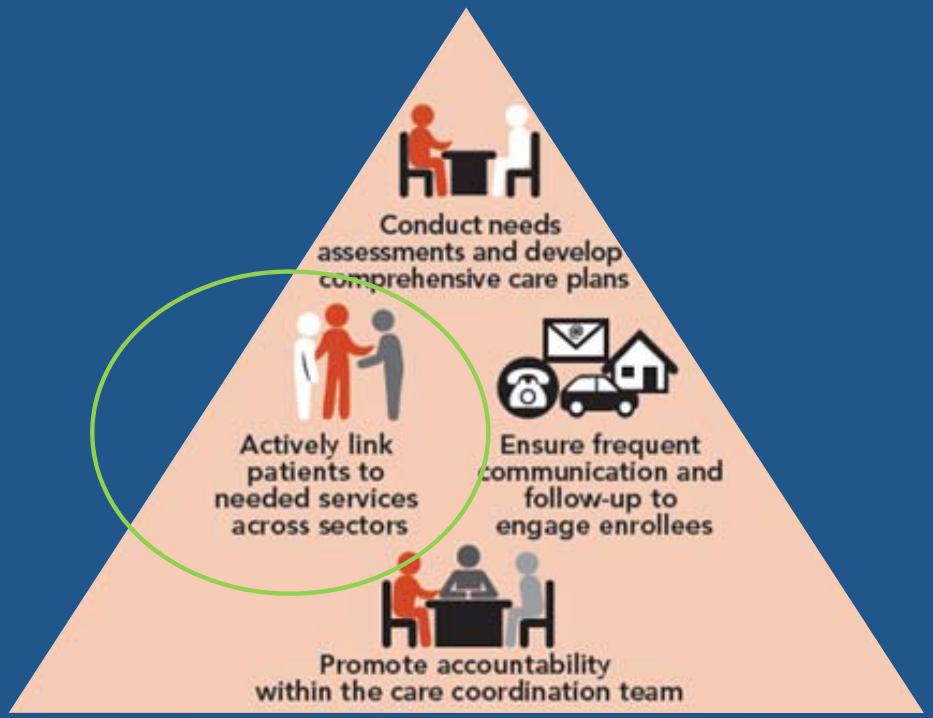
Patient-centered development of a comprehensive care plan

- Full assessment of patient needs
- Comprehensive care plan that prioritizes patient goals

Needs Assessment and Care Plan 

- Pilots required to conduct needs assessment and develop care plan within 30 days of enrollment and repeat at least 1x/year
- Most Pilots (62%) repeated needs assessment and updated care plan >1x/year
- Many Pilots reported use of validated instruments to inform needs assessment process (e.g., VI-SPDAT, PHQ-9, etc.)

Care Coordination: Processes



Use of active referral strategies to link patients to services

- Directly arrange services on patient's behalf
- Accompany to appointments

Active Referral Strategies

- Care coordinators in all Pilots reported use of active referral strategies
- Active referral strategies were identified as particularly critical for Pilots that did not have standardized protocols for referrals, tracking, and/or follow-up
- Multiple Pilots cited limited availability of long-term permanent housing and/or private behavioral health providers accepting Medi-Cal as limiting success of referral efforts

Care Coordination: Processes

Clear accountability for care coordination across care team

Example strategies:

- Regular meetings or case conferences with team

Promoting Accountability Across Care Team

- Pilots were required to identify providers and staff responsible for care coordination as a condition of participation
- All but one Pilot reported use of regular care team meetings to promote accountability for care coordination; some Pilots also implemented case conferences to allow for shared learning
- Potential accountability challenges when >1 partner responsible for care coordination: (1) >1 assigned care coordinator across organizations; (2) Poor communication during hand-offs / transitions

Lessons Learned and Next Steps

- **Invest more time to further develop care coordination infrastructure** – new partnerships and data sharing infrastructure require significant time to "start up"

- **Importance of person-centered practices that effectively engage vulnerable patients in care** – field-based outreach, use of case management in addition to care coordination, benefits assistance to reduce churn, etc.

- **Leverage WPC resources and partnerships when possible** – e.g., to secure expedited access or priority placement for WPC enrollees or to improve availability of services within community

Read more at:

http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1844

Health Policy Brief

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Whole Person Care Improves Care Coordination for Many Californians

Emmeline Chuang, PhD, Brenna O'Masta, MPH, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

"Delivery of integrated services may improve the patient experience and reduce health care use and costs."

SUMMARY: California's Whole Person Care (WPC) Pilots implemented under the Section 1115 Medicaid Waiver, "Medi-Cal 2020," are designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. We examined literature on care coordination and developed a framework for assessing the progress of WPC Pilot implementation in eight key areas. Th into the program, results show that W successfully implemented many esse coordination processes, but they con to further develop needed infrastruct These findings highlight opportunitie challenges in implementing a cross-s coordination program for patients wi health and social needs.

The U.S. health care delivery system has long been fraught with inefficiencies rooted in part in fragmentation of care and professional silos. Frequently, patients with chronic and complex needs must navigate between medical, behavioral health, and social service providers who are not prepared or equipped to provide them with holistic care. Preliminary evidence suggests that delivery of integrated services may improve the patient experience and reduce health care use and costs.[1-3]

In 2016, California began implementing the WPC Pilot demonstration project to promote systematic delivery of coordinated care and evaluate its impact on health care costs and use for Medicaid (called Medi-Cal in California) beneficiaries.[4,5] The WPC Pilot is part of California's Section 1115 Medicaid waiver, known as "Medi-Cal 2020." The aim of WPC is to improve coordin medical, behavioral health, and soc for patients who use a high level of services and ultimately improve pa health and reduce Medi-Cal expend

A total of 25 pilot programs in 26 counties[a] (hereafter referred to as W were established by 2017. All WP were led by a single, designated lea (LE), typically a county Health and Services Agency. These LEs partner health plans and other service prov to coordinate medical, behavioral h and social services for targeted Me beneficiaries. Specifically, WPC Pilots were expected to systematically identify target populations, share data, coordinate care, and evaluate improvements in the health of enrolled populations.

a Twenty-seven counties initially implemented WPC Pilots, but Plumas County (part of the Small County WPC Collaborative with Mariposa and San Benito Counties) dropped out in September 2018.

Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Alameda County

Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Los Angeles County

Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Kings County

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Care Coordination in California's Whole Person Care Pilot Program: Mendocino County

Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: City of Sacramento

Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Ventura County