



THE UCLA CENTER FOR HEALTH POLICY RESEARCH 

# “Whole Person Care Improves Care Coordination for Many Californians”

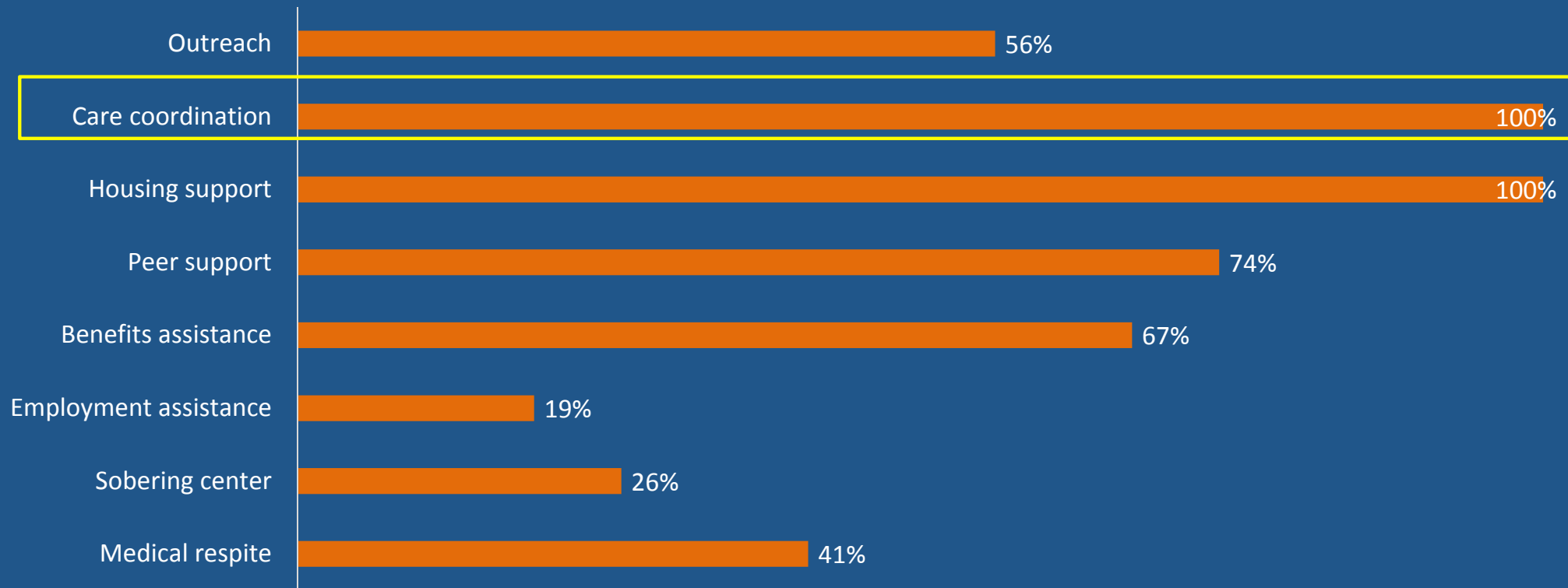
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# Whole Person Care (WPC) Pilot Program

- **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

Pilots Offering (%)



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



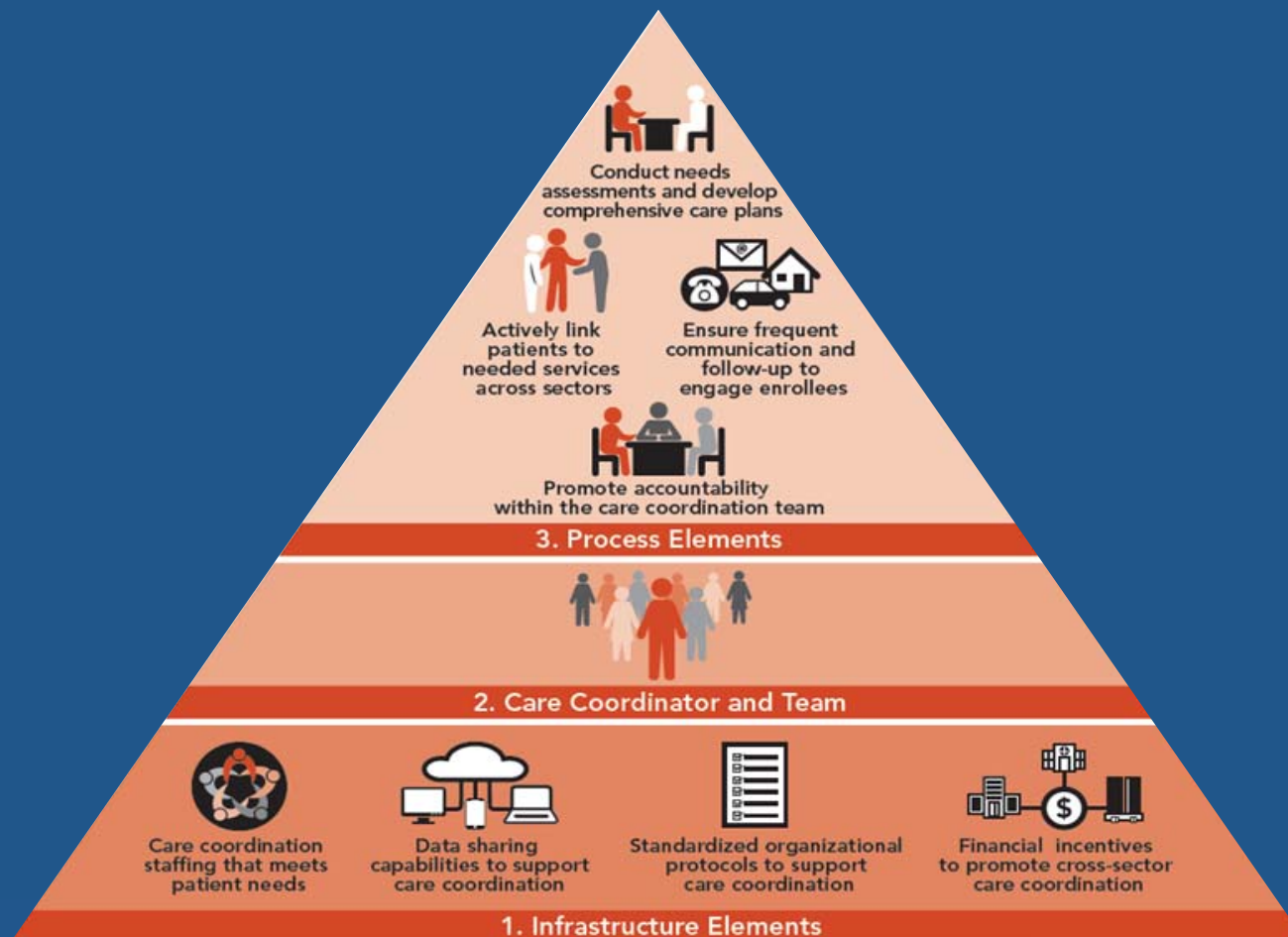
# Defining Care Coordination in WPC

*“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

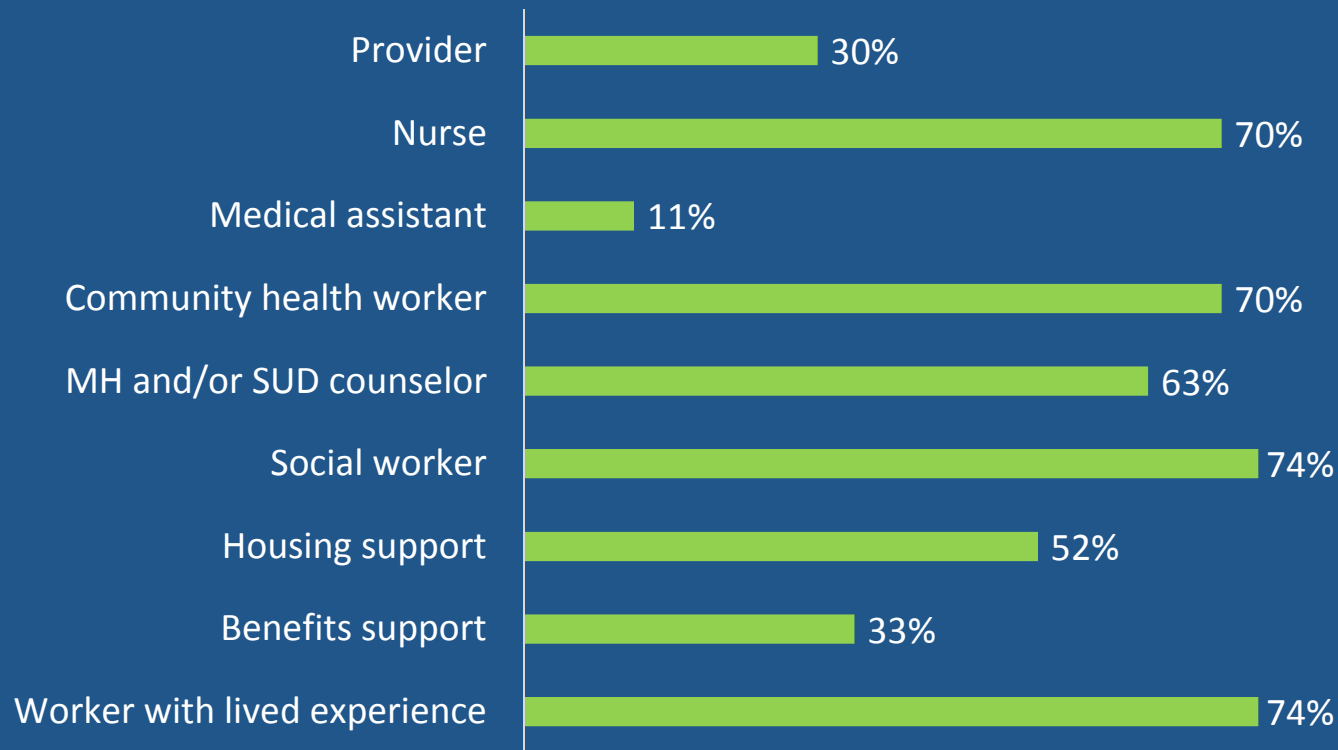


Staff must have the capacity to effectively engage with patients that have a wide range of needs.

- 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



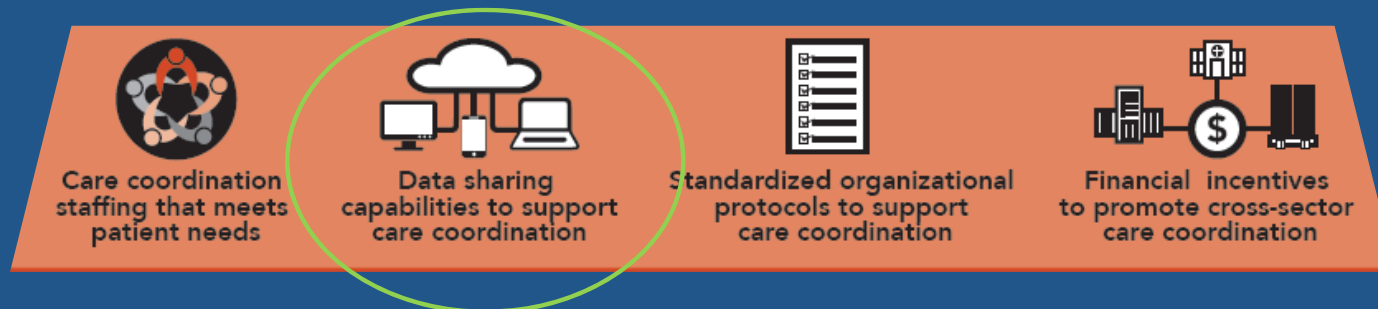
# Care Coordination Staffing: Multidisciplinary Care Team Composition



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.

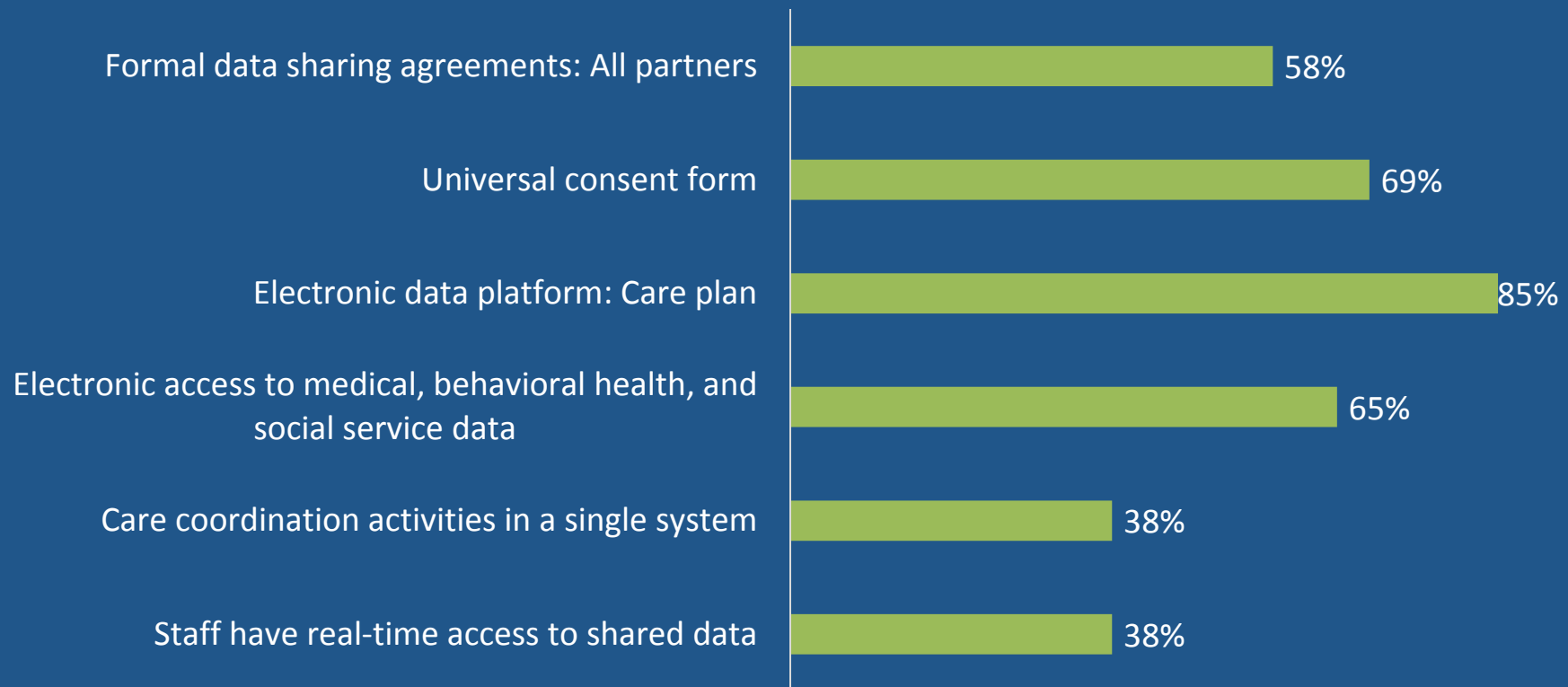
## Care Coordination: Infrastructure



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

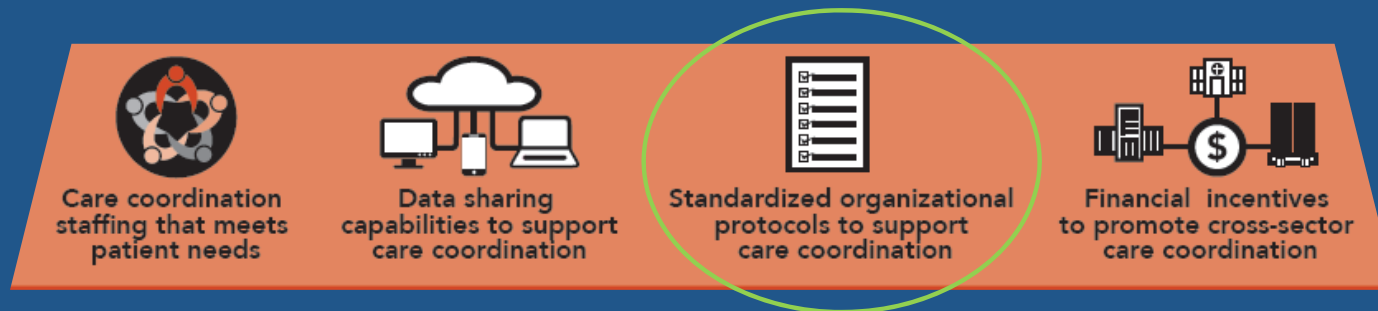
- Formal agreements to define terms and conditions (BAAs, MOUs)
- Universal consent form (can be segmented)
- Electronic data sharing platform

# 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

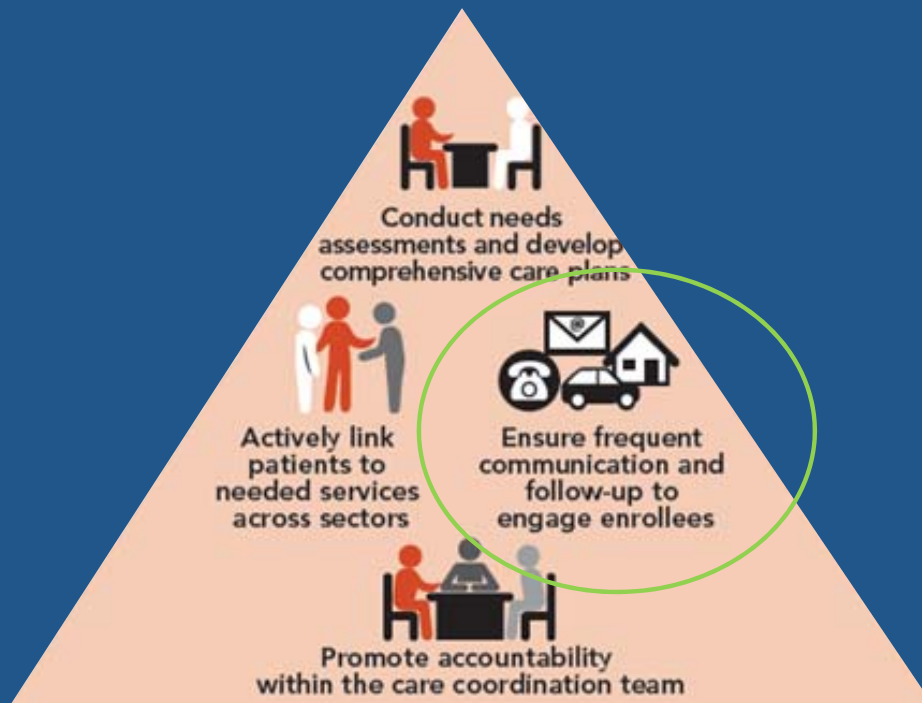
# Care Coordination Protocols

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

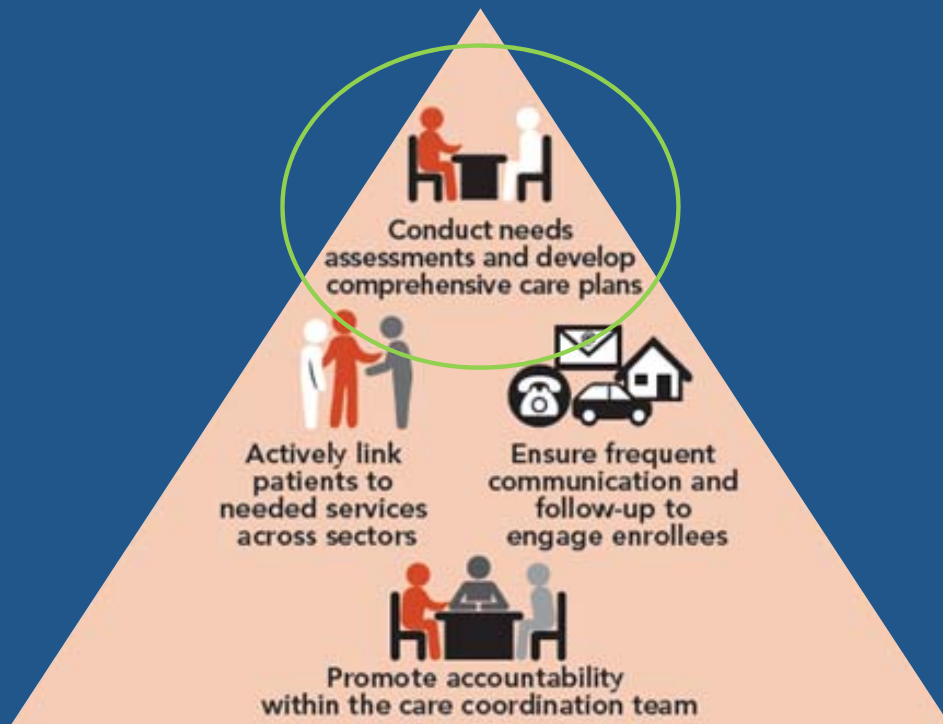


# Patient-Centered Communication



- 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



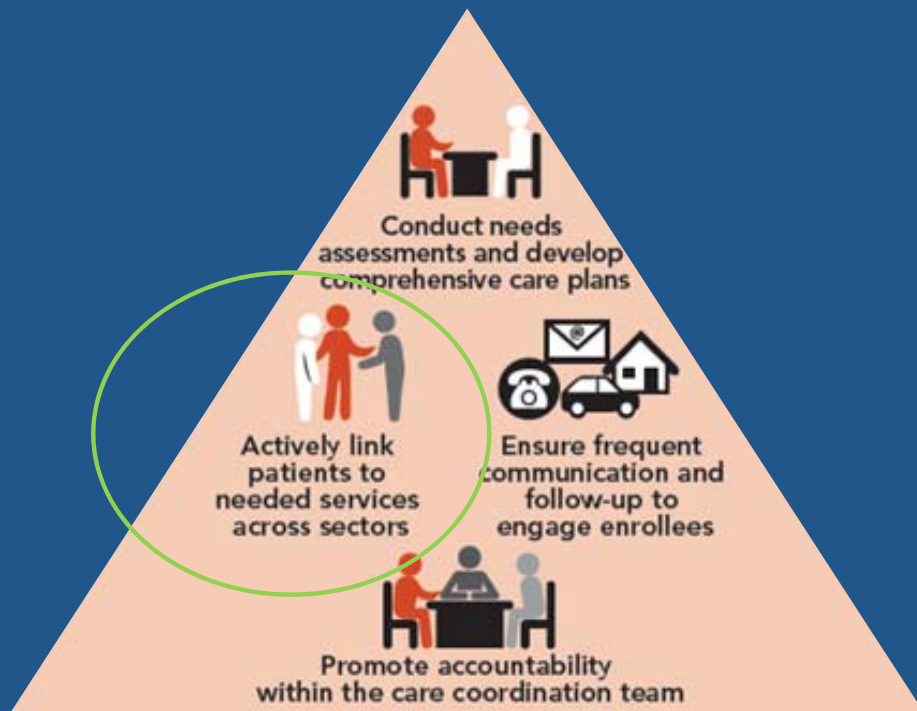
Patient-centered development of a comprehensive care plan

- 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

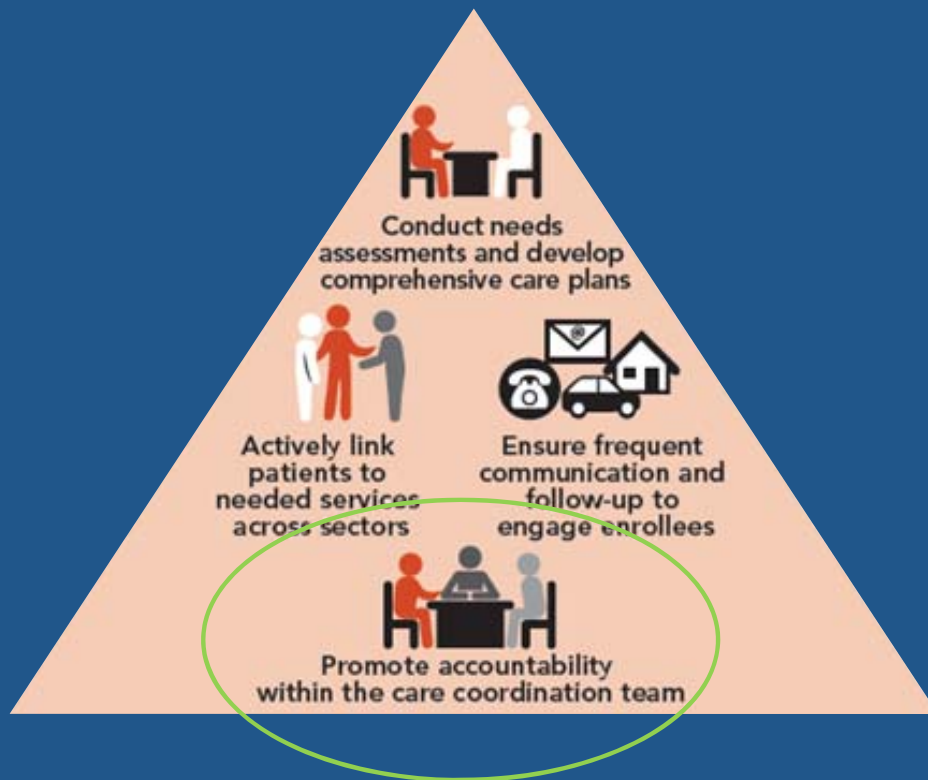


# Active Referral Strategies



- 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

October 2019

### Whole Person Care Improves Care Coordination for Many Californians

Emmeline Chuang, PhD, Brenna O'Masta, MPH, Elaine M. Albertain, 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. To date, the program, results show that WPC has successfully implemented many essential coordination processes, but they continue to further develop needed infrastructure. These findings highlight opportunities and challenges in implementing a cross-agency care coordination and developed a framework for assessing the progress of WPC Pilot

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.<sup>1-3</sup>

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.<sup>4,5</sup> The WPC Pilot is part of California's Section 1115 Medicaid waiver, known as "Medi-Cal 2020." The

aim of WPC is to improve coordination of medical, behavioral health, and social services for patients who use a high level of services and ultimately improve patient health and reduce Medi-Cal expenditure. A total of 25 pilot programs in 26 counties (hereafter referred to as "WPC Pilots") were established by 2017. All WPC Pilots were led by a single, designated lead entity (LE), typically a county Health and Services Agency. These LEs partner with health plans and other service providers to coordinate medical, behavioral health, and social services for targeted Medicaid beneficiaries. Specifically, WPC Pilots were expected to systematically identify target populations, share data, coordinate care, and evaluate improvements in the health of enrolled populations.

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

## Health Policy Case Study

October 2019

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

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

## Health Policy Case Study

October 2019

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

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

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC initiative, we developed a framework to assess elements of cross-agency care coordination implemented by the WPC Pilots. The following document describes care coordination in Los Angeles County WPC Pilot using this framework from implementation to March 2019.

**Background**  
The Los Angeles County Department of Health Services (LACDHHS) worked with over 100 organizations within the County to implement WPC. LACDHHS worked most closely with five county agencies (Mental Health, Public Health, Police, Fire, and Sheriff's Department), two managed care plans (LA Care and Health Net), and multiple third-party providers.

WPC LA implemented 14 programs designed to serve different target populations. These programs included HeadStart Care Supportive Services, Elderly Complex Transition of Care, Reproductive Care, and Community Resource, and more. 13 of these 14 programs included at least one care coordination

services. Eligible services were identified using an open-ended process. Length of enrollment varied depending on the program clients qualified for, but services were largely designed to be transitional (i.e., average program duration: between 1-4 months though could go as high as 9-12 months for high severity cases).

The overall characteristics of Los Angeles WPC Pilot called "WPC-LA" are displayed in Exhibit 1.

**Exhibit 1: Los Angeles WPC Pilot Overview**

Lead Entity	5-Year Period Enrollment	Enrollment Strategy	Primary Target Population(s)
Los Angeles County Department of Health Services (LACDHHS)	141,148	High Utilizers, Clinical Need, Chronic Disease, Serious Mental Illness, and/or Substance Use Disorder, Homeless, At-Risk of Homelessness, Justice Involved	1 County Health and Social Services, 1 Managed Care Plan, 1 Community Partner

WPC LA implemented 14 programs designed to serve different target populations. These programs included HeadStart Care Supportive Services, Elderly Complex Transition of Care, Reproductive Care, and Community Resource, and more. 13 of these 14 programs included at least one care coordination

## Health Policy Case Study

October 2019

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

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

## Health Policy Case Study

October 2019

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

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

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC initiative, we developed a framework to assess elements of cross-agency care coordination implemented by the WPC Pilots. The following document describes care coordination in Mendocino County's WPC Pilot using this framework from implementation to March 2019.

**Background**  
To implement WPC, Mendocino County Health and Human Services Agency (HHS)A) worked most closely with one administrative services organization (Redwood Quality Management Company) and three community partners (Advanced Health Care, Valley Medical Center, and the County of Mendocino Community Health Center).

Eligible services were identified using methods. The Pilot evaluated services every 100 days to determine if the services met needed WPC criteria. In January of 2019, the Pilot implemented a formal graduation system. The overall characteristics of Mendocino's WPC Pilot are displayed in Exhibit 1.

**Exhibit 1: Mendocino WPC Pilot Overview**

Lead Entity	5-Year Period Enrollment	Enrollment Strategy	Primary Target Population(s)
Mendocino County Health and Human Services Agency (HHS)A)	100	High Utilizers, Clinical Need, Chronic Disease, Serious Mental Illness, and/or Substance Use Disorder	1 County Health and Social Services, 1 Managed Care Plan, 1 Community Partner

**2019 Period Enrollment**

1 County Health and Social Services	1 Managed Care Plan	1 Community Partner
1	1	4

**Notes:** Community partner services are being built, some health, and others not being implemented and are managed patients that were not part of the lead entity's enrollment.

To achieve the goals of better care and better health, Mendocino's WPC Pilot focused on enhancing and strengthening the medical and social support systems for individuals with serious mental illness and two other qualifying conditions, including substance use disorder, high utilization of medical expenses, homelessness, or recent law enforcement contact. Specifically, the Pilot focused on improving care through housing support, improving health through increased control of diabetes and hypertension, and improving social connections.

## Health Policy Case Study

October 2019

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

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

## Health Policy Case Study

October 2019

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

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

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC initiative, we developed a framework to assess elements of cross-agency care coordination implemented by the WPC Pilots. The following document describes care coordination in Ventura County WPC Pilot using this framework from implementation to March 2019.

**Background**  
To implement WPC, the Ventura County Health Care Agency (VCHCA) worked most closely with other county agencies (Behavioral Health Department, Continuum of Care, Human Services Agency, and Medical Center), the Medi-Cal managed care plan, and one community partner (e.g., service providers for individuals experiencing homelessness).

Initially, Ventura's Pilot used administrative data from the Medi-Cal managed care plan to identify potential enrollees and then attempted to contact them by telephone and/or in the field. In addition, the Pilot also explored a referral-based system in which eligible enrollees were primarily identified through referrals from

community partners. This referral-based approach allowed patient engagement closer to the point of care and at a time of established need, resulting in a higher referral completion rate.

The overall characteristics of Ventura's WPC Pilot called "Ventura County Whole Person Care Coordinated Pilot" are displayed in Exhibit 1.

**Exhibit 1: Ventura WPC Pilot Overview**

Lead Entity	5-Year Period Enrollment	Enrollment Strategy	Primary Target Population(s)
Ventura County Health Care Agency (VCHCA)	2,546	Referrals and Administrative Data	1 County Health and Social Services, 1 Managed Care Plan, 1 Community Partner

**2019 Period Enrollment**

1 County Health and Social Services	1 Managed Care Plan	1 Community Partner
1	1	22

**Notes:** Community partner services are being built, some health, and others not being implemented and are managed patients that were not part of the lead entity's enrollment.

To achieve the goals of better care, timely access and better health, Ventura's Pilot focused on reducing unnecessary emergency room visits and hospital readmissions, improving housing support services, diabetes and hypertension management control, depression treatment,