“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 (%)

- Outreach: 56%
- Care coordination: 100%
- Housing support: 100%
- Peer support: 74%
- Benefits assistance: 67%
- Employment assistance: 19%
- Sobering center: 26%
- Medical respite: 41%

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

1. Infrastructure Elements
   - Care coordination staffing that meets patient needs
   - Data sharing capabilities to support care coordination
   - Standardized organizational protocols to support care coordination
   - Financial incentives to promote cross-sector care coordination

2. Care Coordinator and Team
   - Conduct needs assessments and develop comprehensive care plans
   - Actively link patients to needed services across sectors
   - Ensure frequent communication and follow-up to engage enrollees
   - Promote accountability within the care coordination team

3. Process Elements
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

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Provider</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse</td>
<td>70%</td>
</tr>
<tr>
<td>Medical assistant</td>
<td>11%</td>
</tr>
<tr>
<td>Community health worker</td>
<td>70%</td>
</tr>
<tr>
<td>MH and/or SUD counselor</td>
<td>63%</td>
</tr>
<tr>
<td>Social worker</td>
<td>74%</td>
</tr>
<tr>
<td>Housing support</td>
<td>52%</td>
</tr>
<tr>
<td>Benefits support</td>
<td>33%</td>
</tr>
<tr>
<td>Worker with lived experience</td>
<td>74%</td>
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</tbody>
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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.
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

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Formal data sharing agreements: All partners</td>
<td>58%</td>
</tr>
<tr>
<td>Universal consent form</td>
<td>69%</td>
</tr>
<tr>
<td>Electronic data platform: Care plan</td>
<td>85%</td>
</tr>
<tr>
<td>Electronic access to medical, behavioral health, and social service data</td>
<td>65%</td>
</tr>
<tr>
<td>Care coordination activities in a single system</td>
<td>38%</td>
</tr>
<tr>
<td>Staff have real-time access to shared data</td>
<td>38%</td>
</tr>
</tbody>
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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
Whole Person Care Improves Care Coordination for Many Californians

Emeline Cheung, PhD, Dionne O'Meara, MPH, Elaine M. Albright, MPH, Leigh Ann Kelley, MPA, Cynthia Lu, MPH, Nadine Houtz, PhD

SUMMARY: California's Whole Person Care (WPC) Pilot Program, implemented under the Section 1115 Medicaid waiver "Medi-Cal 2020," is designed to coordinate medical, behavioral, and social services to improve the health and well-being of enrollees with complex needs. WPC emphasized incentives on care coordination and developed a framework for assessing the progress of WPC Pilot implementation in eight key areas. This report provides results from a successfully implemented program that includes care coordination, health and social services, and outcomes for patients with chronic diseases.

The U.S. health care delivery system has long been beset with inefficiencies and lack of coordination of care among patients and providers. Frequently, patients with chronic diseases can experience fragmented care 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 care may improve the patient experience and reduce health care costs.

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 of Medi-Cal services. The WPC Pilot is part of California's Section 1115 Medicaid waiver, known as "Medi-Cal 2020." The aim of the WPC Pilot is to improve coordinated medical, behavioral health, and social services and ultimately improve patients' health outcomes and reduce health care costs. WPC focuses on care coordination between medical, behavioral health, and social service providers who are not prepared or equipped to provide holistic care. Evidence suggests that delivery of integrated care may improve the patient experience and reduce health care costs.

A total of 25 sites across the state were selected for the WPC Pilot, which began in March 2016. Each site is tasked with developing and implementing integrated care programs for patients with complex health care needs. The WPC Pilot goals are to improve the coordination of care and reduce costs by providing comprehensive, individualized care plans.

In conclusion, the WPC Pilot demonstrates the potential for integrated care to improve patient outcomes and reduce costs. The success of the program suggests that a similar approach could be effective in other states and countries with similar health care challenges.

Read more at: