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

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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 evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots ([found here](#)). The following document describes care coordination under Los Angeles County WPC Pilot using this framework from implementation to March 2019.

### Background

The Los Angeles County Department of Health Services (LACDHS) worked with over 100 organizations within the County to implement WPC. LACDHS worked most closely with five county agencies (Mental Health, Public Health, Public Social Services, Los Angeles Sheriff Department, and Probation), two managed care plans (LA Care and Health Net), and multiple social service agencies.

WPC-LA implemented 16 programs designed for six different target populations. These programs included Homeless Care Supportive Services, Medically Complex Transitions of Care, Recuperative Care, and Community Re-entry, and more; 15 of these 16 programs included at least some care coordination

services. Eligible enrollees were identified using an open referral 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 acuity enrollees).

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

Exhibit 1: Los Angeles WPC Pilot Overview

<b>Lead Entity</b>	Los Angeles County Department of Health Services (LACDHS)		
<b>5-Year Projected Enrollment</b>	140,146		
<b>Enrollment Strategy</b>	Referrals		
<b>Primary Target Population(s)</b>	High Utilizers, Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness, Justice Involved		
<b>118+ Partner Organizations</b>			
2 County Health and Mental Health	6 County Housing, Justice, or Social Services	6 Managed Care Plans	100+ Community Partners <sup>1</sup>

Notes: <sup>1</sup> Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, WPC-LA focused on permanently housing homeless enrollees, reducing jail recidivism, and decreasing 30-day all-cause readmission rates.

### Care Coordination Infrastructure

**Care coordination staffing that meets patient needs.** Care coordination services were provided by community health workers (CHWs) under the supervision of licensed clinical social workers. WPC-LA deliberately included CHWs with personal lived experience similar to that of WPC target populations to help improve enrollee engagement. Caseload varied by program and ranged from 15-40 enrollees depending on enrollee acuity and expected level of engagement.

**Data sharing capabilities to support care coordination.** For all formal WPC partnerships, LACDHS created a Business Associate Agreement (BAA) that included a data-sharing element, and required all formal WPC partners to sign the BAA to participate. WPC-LA also created a segmented universal consent form used by all partners, which allowed enrollees to elect out of sharing particular elements if they wished (e.g., data covered by 42 CFR (Code of Federal Regulations) Part 2, mental health history, HIV test results).

WPC-LA developed a real-time case management platform, Comprehensive Health Accompaniment and Management Platform (CHAMP), specifically for WPC. The main purpose of the platform was to facilitate workflows for frontline staff (e.g., eligibility screens, enrollment and assessments, creation of a care plan with “SMART” goals), store enrollee documents (e.g., universal consent form), and comprehensively document case related information (e.g., updated care plan, attempted contacts with enrollees, case notes). CHWs could access CHAMP remotely while in the field.

Most WPC-LA staff had access to CHAMP, as well as staff in the Office of Diversion and Re-

entry, Housing for Health, Countywide Benefits Entitlement Services Team, and Intensive Case Management Service providers.

As of fall 2018, CHAMP did not yet exchange data or interface with other electronic systems, though LACDHS ultimately planned to implement a comprehensive data system with real-time feeds from multiple sources. Ideally, they aimed to include data from county Health Services, Social Services, Mental Health, Public Health (DPH), Housing for Health, jails/Sheriff's Department, courts, and managed care plans.

**Standardized organizational protocols to support care coordination.** Los Angeles' Pilot included standardized protocols around patient assessment and care plan development. As of fall 2018, the Pilot had not yet developed standardized protocols for making social services referrals and monitoring referral status, but had plans to implement protocols in the future. To help facilitate that process, in 2018 WPC-LA began utilizing a mobile community resource platform called OneDegree.

**Financial incentives to promote cross-sector care coordination.** WPC-LA services were reimbursed using 15 different per-member-per-month (PMPM) bundles and one fee-for-service (FFS) bundle, each corresponding to a different WPC-LA program. WPC-LA funded additional programs through incentives. For most WPC-LA programs, LACDHS either (1) created new county positions and hired staff to deliver services in-house; or (2) contracted with community partners to deliver the service.

### Care Coordination Processes

**Ensure frequent communication and follow-up to engage enrollees.** Los Angeles' Pilot used a variety of settings and modes to initiate contact with eligible enrollees across WPC-LA programs (e.g., in hospitals for transitions of care, etc.). The most common form of outreach was in-person, by meeting enrollees where they were (e.g., in hospital or at primary care visit). CHWs maintained contact with enrollees

through a variety of mechanisms, but primarily by a mix of telephone and in-person visits.

**Conduct needs assessments and develop comprehensive care plans.** Care coordinators performed a formal needs assessment at intake; the primary goal of the first CHW-enrollee visit was to assess enrollee needs and to build trust. WPC-LA developed an “in-house” needs assessment tool that CHWs accessed through CHAMP. The assessment, which included validated instruments, captured medical, social determinants of health, mental health and substance use disorder (SUD) history, and food insecurity. As appropriate, care coordinators also used the Vulnerability Index - Service Prioritization Decision Assistance Tool to provision housing support services. Results of the needs assessment were used to develop a person-centered care plan, which CHWs were required to update regularly.

**Actively link patients to needed services across sectors.** WPC-LA’s CHWs used active referral strategies to refer their enrollees to needed medical care, behavioral health care, and social services. For example, CHWs were described as frequently accompanying enrollees to appointments.

**Promote accountability within care coordination team.** In order to ensure accountability within the care coordination team, WPC-LA required the CHWs to participate in weekly meetings with their supervisor. Supervisors were expected to review case notes and care plan progress, and discuss strategies for supporting high-need clients with CHWs. In addition, when not in the field, teams were centrally located at Regional Coordinating Centers to facilitate face-to-face meetings, sharing of lessons learned, and urgent consultations amongst care coordination teams, as needed.

### Suggested Citation

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