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Whole Person Care Improves Care Coordination for Many Californians

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“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. Three years into the program, results show that WPC Pilots successfully implemented many essential care coordination processes, but they continued to further develop needed infrastructure. These findings highlight opportunities and challenges in implementing a cross-sector care coordination program for patients with complex 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 coordination of medical, behavioral health, and social services for patients who use a high level of Medi-Cal services and ultimately improve patient health and reduce Medi-Cal expenditures.

A total of 25 pilot programs in 26 selected counties^a (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 Human Services Agency. These LEs partnered with health plans and other service providers to coordinate medical, behavioral health, and social services for targeted Medi-Cal 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.

“Effective cross-sector care coordination requires timely sharing of information among the care coordination team and providers.”

Acknowledging heterogeneity in how publicly funded services are structured and delivered across California, WPC Pilots had considerable flexibility in the selection of target populations, outreach methods, services provided, and outcomes tracked. WPC Pilots also differed significantly in the amount of WPC funds requested and allocated to develop infrastructure for care coordination.⁶ Information on specific characteristics of each WPC Pilot is provided in Appendix 1: <https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/wpc-appendix-datatable.pdf>.

What is Care Coordination?

The Agency for Healthcare Research & Quality (AHRQ) defines care coordination as “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.”⁷ Care coordination is distinct from care management, which is more focused on management of chronic medical and psychosocial conditions, and from case management, which includes services that help patients develop skills to access services and meet their basic needs.⁹ We drew on elements of care coordination identified by AHRQ and an extensive review of the literature to develop a framework of elements critical for cross-sector care coordination. We then used this framework to assess care coordination under WPC.

Cross-Sector Care Coordination Framework

Cross-sector care coordination requires availability of infrastructure to support delivery of effective care coordination processes (Exhibit 1).

Care coordination infrastructure elements include (1) care coordination staffing that meets patient needs, (2) data sharing capabilities to support care coordination, (3) standardized organizational protocols to support care coordination, and (4) financial incentives to promote cross-sector care coordination.

Care coordination staffing that meets patient needs. To successfully coordinate care across sectors, staff must have sufficient capacity to effectively engage with patients to address a wide range of medical, behavioral, and social needs. Staffing levels appropriate for meeting patient needs include (1) developing a multidisciplinary team with relevant and diverse clinical expertise, (2) inclusion of peers with lived experience to build trust and promote compliance of complex patients, and (3) staff workload that ensures sufficient availability to meet patient needs.¹⁰⁻¹²

Data sharing capabilities to support care coordination. Effective cross-sector care coordination requires timely sharing of information among the care coordination team and providers. Data sharing infrastructure that facilitates this type of information exchange includes (1) formal agreements that define terms and conditions of data sharing with key partners; (2) a universal consent form to reduce barriers to sharing patient data; (3) use of an electronic data sharing platform that includes key information such as comprehensive care plans; (4) medical, behavioral health, and social service use data; and (5) capacity to track and report care coordination activities. Ideally, care coordinators can also access this data sharing system to (6) view and enter data (7) remotely (i.e., in the field) and (8) in real-time.¹³⁻¹⁵

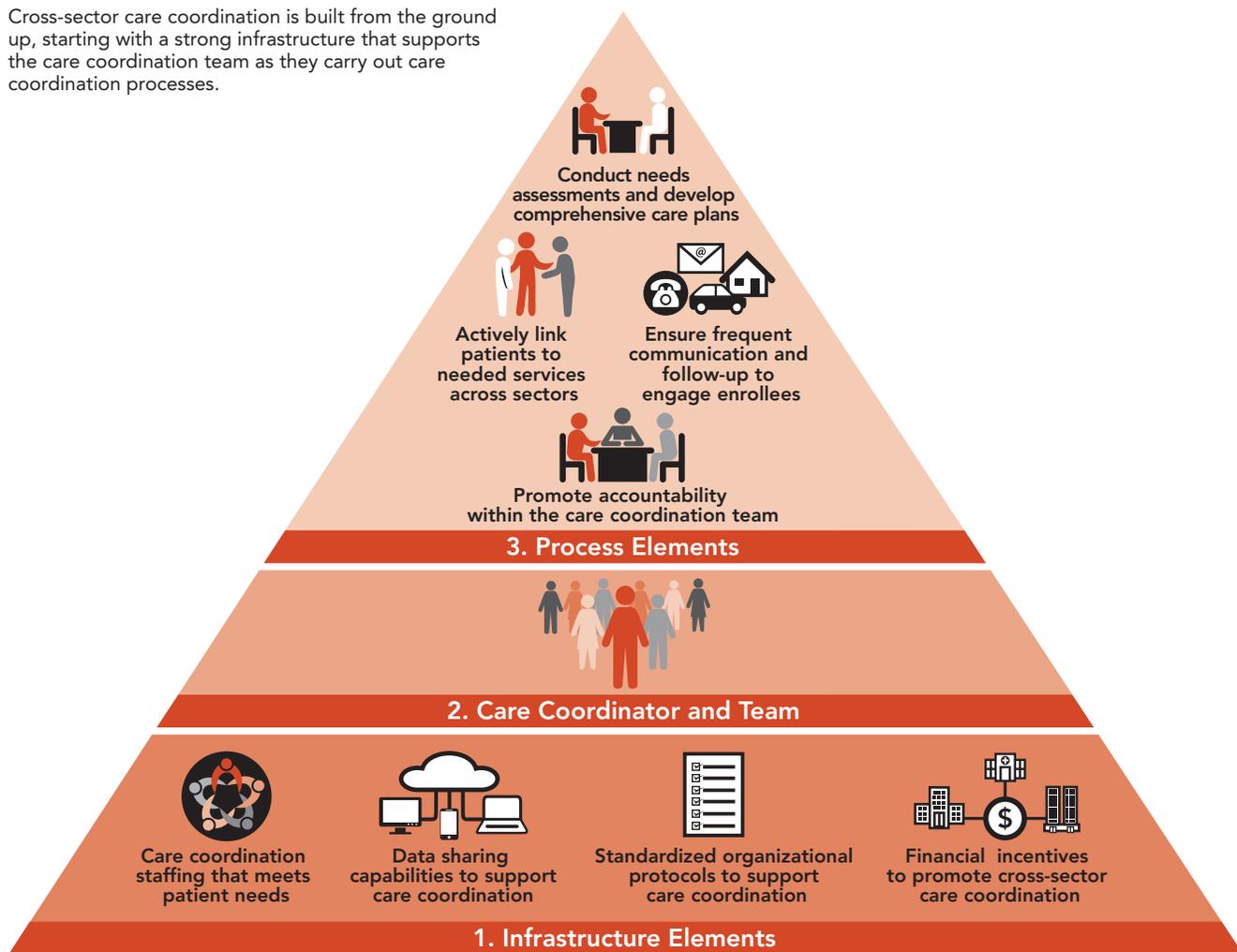
Standardized organizational protocols to support care coordination. Standardized protocols help minimize undesirable variation in delivery of care coordination services.¹⁶ These include protocols for (1) referring patients to needed medical, behavioral, and social services; and (2) monitoring receipt of services and tracking patient outcomes.

Financial incentives to promote cross-sector care coordination. Financial incentives can facilitate organizational buy-in and accountability for cross-sector care coordination.^{3,17} Financial incentives that help align organizational priorities with these care coordination goals

Conceptual Framework of Cross-Sector Care Coordination

Exhibit 1

Cross-sector care coordination is built from the ground up, starting with a strong infrastructure that supports the care coordination team as they carry out care coordination processes.



include use of payment mechanisms that (1) are risk-stratified and address financial risk assumed by providers and (2) reward better performance via incentive payments.

Care coordination process elements include (1) ensuring frequent communication and follow-up to engage enrollees, (2) conducting needs assessments and developing comprehensive care plans, (3) linking patients to needed services and follow-up to ensure receipt of services, and (4) following protocols to promote accountability among care coordination teams.

Ensure frequent communication and follow-up to engage patients. Effectively engaging complex patients in care coordination requires the

adoption of patient-centered communication strategies. These include outreach or other contact with patients (1) in-person, at least initially, to build trust and engagement; (2) wherever and whenever they can be found, including in the field; and (3) frequent follow-up, i.e., more than once per month.¹⁸

Conduct needs assessments and develop comprehensive care plans. Full assessment of patient medical, behavioral, and social needs is essential to developing a comprehensive care plan. These care plans identify patient goals, the actions needed to achieve these goals, and resources or supports needed to ensure successful delivery of care.^{14,15,19} Patients should have a single care plan shared across all providers that is updated regularly

Exhibit 2 Care Coordination Infrastructure in WPC Pilots

Care coordination framework element	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa	Mendocino	Monterey	Napa	Orange	Placer	Riverside	Sacramento	San Benito	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura	Total Pilots
Care coordination infrastructure																											
Care coordination staffing that meets patient needs																											
Multidisciplinary care coordination team composition*	CHW, N, SW, MD, H	CHW, N, SW, C, MH, BS, H	MA, MD, SW	CHW, BS, H, MH, C	CHW, SW	MA, N, SW, MH, H	MH, N, MD, H, SW	N, MH, BS, H, C, CHW	N, MH, SW, C, H, BS	SW, CHW, MH, N, H	MH, N, SW, CHW	CHW, N	N, MH, C, H, BS, CHW	CHW, N, SW, H	SW	CHW, C, N, SW	SW, CHW, MD, H, N	CHW, N, MH, MD, SW	MH, CHW, N	CHW, SW, N, MD, C	CHW, SW, N, MD, MH	SW	N, SW, BS, H	SW, CHW, H, MH, C, BS	C, BS, MH, SW, H, CHW, N	N, MH, CHW, MA, C, BS, H, MD	1
Use of workers with lived experience	•	•		•	•	•		•		•	•	•	•	•		•	•	•		•	•	•		•	•	•	20
Workload**	20-30	90-350	125-150	10-20	15-40	17-30	20-25	15-20	40	40	10-60	15	70-100	25-75	8-10	50	10-25	20-30	15-150	12-30	10-50	25	20-25	20	15	60	Median = 20-30
Data sharing capabilities to support care coordination																											
Data sharing agreements among key partners	Some	All	Some	All	All	All	All	Some	All	Some	All	Some	All	Some	Some	All	All	Some	Some	Some	All	All	All	All	All	Some	All=15, Some=11, None=0
Universal consent form	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	18
Electronic capture of comprehensive care plan	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	22
Frontline staff track and report on care coordination activities in a single electronic system	•	•		•		•	•		•		•		•		•	•	•								•		10
Read and write access to shared data for frontline staff	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	21
Real-time access to shared data for frontline staff	•	•									•	•					•			•	•				•	•	9
Remote access to shared data for frontline staff	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•				•		•	•	•	17
Access to medical, behavioral health and social service data	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17

Data Source: WPC applications, mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services, interviews conducted with representatives of each Pilot from September 2018 to March 2019, and surveys of WPC organizations administered in the summer and fall of 2018.

* Types of staff directly involved in care coordination: CHW=Community Health Worker or Peer Support, MA=Medical Assistant, N=Nurse or Licensed Vocational Nurse, SW= Social Worker, C= Alcohol and Drug Counselor, MD=Physician or Nurse Practitioner, MH=Mental Health Professional/Counselor, BS=Benefit Support (includes job support), H=Housing Support.

** Workload refers to the average number of enrollees per care coordinator. Wide workload ranges were typically associated with WPC Pilots' use of risk-stratified PMPM bundles, in which intensity of services was tailored based on enrollee risk. In these situations, care coordinators working with higher acuity enrollees often had significantly lower caseloads than those working with lower acuity enrollees.

Care Coordination Infrastructure in WPC Pilots (continued)

Exhibit 2

Care coordination framework element	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa	Mendocino	Monterey	Napa	Orange	Placer	Riverside	Sacramento	San Benito	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura	Total Pilots	
Care coordination infrastructure																												
Standardized organizational protocols to support care coordination																												
Standardized referral protocols	•	•	•	•	•		•		•	•	•	•	•		•										•	•	•	16
Standardized protocols for monitoring and follow-up		•	•	•	•	•			•	•	•		•		•	•	•	•							•	•	•	17
Financial incentives to promote cross-sector care coordination																												
Risk-stratified PMPM bundles [†]	•	•		•	•			•			•			•				•				•				•	•	10
Contracted care coordination services (All)	All	None	None	All	Some	All	None	All	Some	All	All	None	None	All	None	None	All	Some	All	Some	Some	Some	Some	All	Some	Some	All=10, Some=9, None=7	
Financial incentives for contractors ^{††}	•	-	-			•	-	•	•	•		-	-	•	-	-	•		•	•	•	•	•		•	•	14	

† Pilots were identified as having risk-stratified PMPM bundles when enrollees were stratified into different PMPM bundles at intake based on an assessment of risk.

†† Financial incentives for contractors were assessed only when care coordination services were contracted out rather than provided directly by the lead entity.

to address changes in patient needs over time, i.e., more frequently than once per year.

Actively link patients to needed services across sectors. Active referral strategies, e.g., through directly arranging services on the patient’s behalf, are more effective in service uptake than informational referral strategies, such as giving patients information about available treatment options and leaving them to navigate the rest.¹⁶ Successful care coordination includes active referral to needed medical and behavioral health, including mental health or substance abuse treatment, and social services such as housing or benefits assistance.

Promote accountability within the care coordination team. Care coordination is most effective when accountability for different activities is clearly defined and monitored. Strategies that support accountability for care coordination could include regular meetings

and case conferences with care coordinators or care teams to share expertise, negotiate differences in judgment, and define priorities for patient care.²⁰

Evaluation of Care Coordination under WPC

Data for the evaluation of care coordination under WPC was gathered between September 2018 to March 2019 using WPC applications, a structured survey, and follow up interviews with leaders, care coordinators, and other WPC Pilot staff.^b Additional details about care coordination efforts of individual WPC Pilots can be found here: <https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1844>.

Infrastructure

WPC Pilots reported significant progress in establishing the infrastructure needed to coordinate the care of enrollees in the first 3 years of implementation (Exhibit 2).

“Care coordination is most effective when accountability for different activities is clearly defined and monitored.”

b See Data and Methodology section.

“Over half of WPC Pilots reported successfully sharing comprehensive medical, behavioral health, and social services data with partners.”

Pilots differed, however, in infrastructure investments, data sharing, and other infrastructure in place prior to WPC.

Care coordination staffing that meets patient needs. Staffing varied across and within WPC Pilots based on target population(s) and identified needs. Care coordination services were often provided by non-clinical staff such as community health workers. Due to the complexity of enrollee care needs, however, all care coordination teams included at least some staff with clinical expertise (e.g., providers, nurses, social workers). Many WPC Pilots also used peers with lived experience (e.g., previously incarcerated or homeless peers) to help build trust and rapport with enrollees. Staff workload varied considerably across WPC Pilots depending on projected acuity of the target population and intensity of contact with enrollees.

Data sharing capabilities to support care coordination. WPC Pilots were required to develop new data sharing capabilities. By 2018, all 25 WPC Pilots had at least some formal data sharing agreements with key partners. Many had developed universal consent forms for sharing patient data, and nearly all used an electronic data sharing platform that included information on comprehensive care plans. WPC Pilots that did not yet have these capabilities reported challenges such as vendor delays and difficulty obtaining partner buy-in. Yet they typically had temporary solutions to facilitate data sharing (e.g., ShareFile, SharePoint, Box) until more efficient and permanent systems could be procured or implemented. Over half of WPC Pilots reported successfully sharing comprehensive medical, behavioral health, and social services data with partners. Pilots that did not yet share behavioral health data typically identified federal confidentiality laws protecting the privacy of substance use disorder patient records (42 CFR Part 2) as a major barrier. Less than half of WPC Pilots reported providing frontline staff with real-time notifications about patient events, such

as emergency department visits, but most WPC Pilots without this capability identified developing real-time notifications as a future priority.

Standardized organizational protocols to support care coordination. Around half of WPC Pilots had standardized protocols in place for referring enrollees to needed services (e.g., checklists) and tracking or following up with enrollees to assess referral outcomes. Several WPC Pilots cited the heterogeneity of enrollee service needs as a barrier to developing standardized referral protocols, particularly when referral processes were not integrated with an existing electronic platform to facilitate tracking. Pilots that contracted out care coordination services to multiple partners also cited partner preferences for developing and maintaining their own internal protocols as a barrier to standardization.

Financial incentives to promote cross-sector care coordination. Pilots were primarily reimbursed for care coordination under WPC using per-member, per-month (PMPM) payments for a bundle of services, though some received fee-for-service reimbursement to deliver additional services (e.g., outreach and engagement, assessments and screening). Eleven WPC Pilots stratified their PMPM bundles based on enrollee acuity or risk and tailored service intensity. The majority contracted with one or more external organizations (e.g., local health clinics or private social services providers) to supply some or all of their care coordination services. Of these, over half included financial incentives in contracts linked to the achievement of specific outcomes aligned with WPC goals (e.g., improving quality of documentation or scheduling a follow-up primary care visit within 7 days of hospital discharge).

Care Coordination Processes

WPC Pilots also reported significant progress in implementing key processes necessary

Care Coordination Processes in WPC Pilots

Exhibit 3

Care coordination framework element	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa	Mendocino	Monterey	Napa	Orange	Placer	Riverside	Sacramento	San Benito	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura	Total Pilots	
Care coordination processes																												
Ensure frequent communication and follow-up to engage patients																												
Enrollee contact more than once per month	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Field-based outreach	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Frequent in-person, on-going communication with enrollees	•	•		•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•		•	•	•	•	•	•	23
Conduct needs assessment and develop comprehensive care plan																												
Needs assessment more than once per year	•		•	•	•		•		•	•			•	•	•		•	•	•		•			•		•	16	
Single shared care plan	•	•		•	•	•	•		•	•	•	•	•	•	•		•	•			•		•	•	•	•	20	
Actively link patients to needed services across sectors																												
Active referral to medical care	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Active referral to behavioral health care	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Active referral to social services	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Promote accountability within the care coordination team																												
Regular meetings with team to promote accountability	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•	25

Data Source: WPC applications, mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services, interviews

conducted with representatives of each Pilot from September 2018 to March 2019, and surveys of WPC organizations administered in the summer and fall of 2018.

for effective cross-sector care coordination (Exhibit 3). Their specific approach to these processes varied largely due to their WPC Pilot’s target populations and the level of intensity of services they aimed to provide.

Ensure frequent communication and follow-up to engage patients. Many WPC Pilots required care coordinators to contact enrollees at least once per month. However, care coordinators in nearly all WPC Pilots reported contacting enrollees more frequently based on patient need. Most also reported using and prioritizing in-person outreach in the field rather than contacting enrollees by telephone. WPC Pilots described field-based outreach as particularly important for identifying and engaging homeless enrollees.

Assess patient needs and develop a comprehensive care plan. WPC Pilots were required to assess enrollee needs and develop a comprehensive care plan within 30 days of enrollment in WPC and, when appropriate, to repeat this process at least once per year. In practice, most WPC Pilots required care coordinators to re-assess enrollee needs and update care plans more frequently. To assist with accurate identification of needs, many WPC Pilots reported the use of validated instruments such as the Vulnerability Index—Service Prioritization Decision Assistance Tool and the Patient Health Questionnaire-9.

Actively link patients to needed services across sectors. All WPC Pilots reported use of active referral processes such as accompanying enrollees to appointments or facilitating

“Field-based outreach was particularly important for identifying and engaging homeless patients.”

“Continued investment in data sharing capabilities, staff training, and other infrastructure are needed to support effective cross-sector care coordination.”

warm hand-offs to medical, behavioral health, and social service providers. WPC Pilots reported perceived benefits of active referral to include the ability to ensure enrollees received important services, provide immediate follow-up after service receipt, and create additional opportunities for care coordinators to interact with enrollees and monitor enrollee needs and progress. Among WPC Pilots without standardized protocols for referral tracking and follow-up, active referral strategies were viewed as critical for helping informally “close the loop” on referrals.

Promote accountability within the care coordination team. WPC Pilots were required to identify providers and staff responsible for care coordination. Almost all WPC Pilots reported use of regular team meetings to keep one another informed of enrollee progress and promote accountability for care coordination activities. A number of WPC Pilots also reported regular case conferences or other opportunities to share challenges and brainstorm potential solutions. Accountability was generally described as more challenging in WPC Pilots where responsibility for care coordination was distributed across many partners. In these WPC Pilots, challenges included lack of consistency in care coordination activities, the potential for enrollees to have multiple designated care coordinators across different organizations, and a greater need for careful communication during hand-offs across organizations.

Future Steps

Our interim examination showed many WPC Pilots made significant progress in building needed infrastructure and delivering cross-sector care coordination services. By mid-2018, many WPC Pilots had successfully hired care coordinators, shared data across sectors despite multiple challenges, created standardized protocols to support care

coordination activities, and built financial incentives for performance into contracts with providers. Many WPC Pilots also established care processes to engage enrollees in care, developed comprehensive care plans, actively linked patients to needed services, and promoted accountability among care coordination teams. All Pilots described WPC as an important opportunity to improve cross-sector relationships and build more effective systems of care within their communities.

The implementation of WPC included significant and numerous challenges. Pilots acknowledged the need for further progress in multiple areas to achieve overarching WPC goals of better care, better health, and better efficiency. Our analyses identified specific strategies to address these challenges:

Invest more time to further develop the infrastructure to support cross-sector care coordination. Many WPC Pilots had limited or no cross-sector data sharing capabilities prior to WPC. Pilots that successfully created this infrastructure reported investing a significant amount of time, typically more than originally anticipated, to accomplish their goals within the first few years of implementation. Universal consent forms facilitate information sharing, but WPC Pilots noted the need to plan significant time for review by legal counsel in different organizations. WPC Pilots located in counties in which the majority of services were contracted out to private agencies emphasized the importance of allocating sufficient time to ensure partner buy-in and to align financial incentives within contracts with WPC goals. All WPC Pilots reported the importance of continued investment in data sharing capabilities, staff training, and other infrastructure needed to support effective cross-sector care coordination, even mid-implementation.

Promote person-centered practices that more effectively engage vulnerable patients in care. Pilots recognized the need for patient-centered outreach, communication, and referral strategies to engage enrollees in WPC services. Successful strategies reported by WPC Pilots to help foster enrollee self-efficacy included using case management in addition to care coordination to more effectively serve enrollees, the hiring of clinical staff that were only funded part-time by WPC to allow for direct provision of services as part of initial outreach and engagement efforts, and providing benefits assistance to help reduce Medi-Cal churn. All Pilots also reported ongoing adjustment of WPC programs (e.g., by reducing care coordinator caseloads or clarifying scope of work) to better meet enrollee needs.

Leverage WPC resources and partnerships to help address structural problems outside of WPC Pilots' control. Multiple WPC Pilots cited limited availability of long-term, permanent housing as a barrier. Similarly, several small and rural counties cited difficulties with recruitment and retention of staff and limited availability of private behavioral health providers accepting Medi-Cal as barriers to timely access to behavioral health services. Strategies used by some WPC Pilots to address this issue included leveraging WPC to ensure expedited access or priority placement for their enrollees and developing innovative partnerships to improve availability of services within the community, e.g., working with private homeowners to place people in new types of housing.

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Data and Methodology

UCLA developed the care coordination framework following a systematic review of the literature on cross-sector care coordination. Screening of 1,694 articles identified 27 articles addressing interventions to coordinate health and social services for high-use patient populations. These articles were evaluated for key themes and trends and directly informed the conceptual framework used in this report. Qualitative data sources used to assess WPC Pilot care coordination activities included WPC applications, mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services, semi-structured interviews conducted with key informants from each Pilot between September 2018 to March 2019 (n=27), and web-based surveys administered from July 2018 to October 2018 to key program staff in WPC Pilot Lead Entities (n=27) and Partners (n=227). UCLA coded reports and interviews for themes by multiple coders to ensure validity. Analysis were completed using NVivo 12.0 software. Analysis of survey data was completed using Excel and Stata 13.1.

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Endnotes

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