Final Evaluation of Whole Person Care: Selected Findings

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California's Whole Person Care (WPC) Pilot Program was implemented from 2016–2021 to provide care coordination and other supportive services to improve care, health, and reduce costs for high-utilizing Medi-Cal (Medicaid) beneficiaries. Selected findings from the UCLA Center for Health Policy Research evaluation of WPC include:

25 PILOTS IMPLEMENTED WPC

Individuals targeted for enrollment were/had...

247,887 unique Medi-Cal beneficiaries were enrolled

27% had 3+ chronic conditions *and/or*
70% had serious mental illness, had substance use disorder, and/or were experiencing homelessness

PARTNERS

GOAL 1

Increase integration and collaboration between WPC partners.

How Pilots achieved this goal:

543 partners were contracted (8–50 per Pilot)

17% social service organizations

15% housing support service organizations

8% behavioral health providers

Effective partner engagement strategies included:

- regular meetings
- case conferences
- financial incentives for participation and data sharing

CONCLUSION

Pilots succeeded in meaningful engagement of diverse partners, which contributed significantly to improving care of enrollees.

DATA SHARING

GOAL 2

Improve data collection and sharing among WPC partners.

How Pilots achieved this goal:

20 established memorandums of understanding (MOU) and business associate agreements (BAA) with all key partners for data sharing

24 established universal patient consent forms

19 used electronic care management platforms to coordinate care

17 provided real-time alerts of hospitalizations and emergency department (ED) visits

CONCLUSION

Pilots developed new tools for tracking care coordination activities, integrated care coordination data with existing electronic health records, and/or used shared data for quality improvement and decision making.

CARE COORDINATION

GOAL 3

Increase coordination of care for high-risk, high-utilizing beneficiaries.

How Pilots achieved this goal:

ALL had multidisciplinary teams

18 used community health workers/staff with lived experience

18 co-located mental health (10) or housing (8) staff

15 used tiers for care coordination intensity to match enrollee need

24 ensured warm-handoffs and provided transportation

25 enrollees average caseload per care coordinator per Pilot (range 10–300)

PROGRAM IMPACT

GOAL 4

Increase access to care and reduce emergency department (ED) and hospital use.

How Pilots achieved this goal:

Impact on utilization and cost compared to similar Medi-Cal beneficiaries not in WPC. Figures shown are per 1,000 beneficiaries per year:

45 fewer hospitalizations

130 fewer ED visits

56 more substance use disorder services

133 more specialty care services

$383 less in Medi-Cal payments per beneficiary per year

GREATER DECLINE in...

- Acute care utilization for enrollees with serious mental illness/substance use disorder/experiencing homelessness
- Overall payments for medically complex/otherwise high-risk enrollees

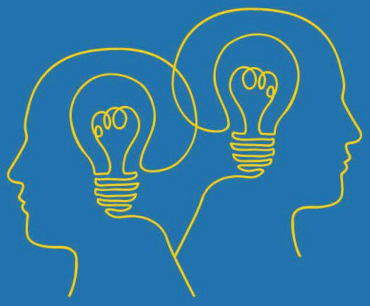
CONCLUSION

Pilots succeeded in coordinating care of enrollees by ensuring accountability and support (tools, resources) to care coordinators.

CONCLUSION

WPC increased access and reduced acute care utilization and costs. Impact on patterns of care differed based on complexity of enrollee needs.

All Pilots or partners have transitioned to providing Enhanced Care Management (ECM) and/or Community Supports (CS) under California Advancing and Innovating Medi-Cal (CalAIM).



IMPLICATIONS

- Ongoing implementation and expansion of ECM and CS to new localities or other states contemplating similar interventions would benefit from WPC best practices.
- Evaluating the impact of CalAIM should take into account that ECM and CS interventions are likely to have a differential effect on enrollees with complex health and social needs.

Read the full WPC report: https://ucla.in/3XXVqnj

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