

ISSUE BRIEF: WHOLE PERSON CARE

GOING BEYOND MEDICAL SERVICES TO HELP VULNERABLE CALIFORNIANS LEAD HEALTHY LIVES

INTRODUCTION

Many factors impact health. For people in low-income communities, medical problems can be caused and exacerbated by factors related to poverty—also referred to as social determinants of health—including poor nutrition, lack of safe and stable housing, incarceration, literacy challenges, unemployment, and the chronic anxiety of income insecurity.

While services may be available to help alleviate some of these stresses and inequalities, they can often be delivered in a siloed fashion, where different types of service providers do not regularly communicate or coordinate, even though they may be serving the same individuals and families.

Appreciating the importance of social determinants of health, California’s public health care systems¹ and other providers are increasingly taking a “whole person” approach to care that extends far beyond traditional health care services.

Helping Patients Lead Healthier Lives

The concept of Whole Person Care (WPC) is premised on the recognition that the best way to care for people with complex issues is to consider their full spectrum of needs—medical, behavioral, socioeconomic and beyond—in a coordinated and integrated way. Patients receiving WPC can have a better experience of care, as their needs are more fully addressed without having to navigate multiple programs and systems on their own. By receiving customized support to help meet their fundamental needs, patients can ultimately enjoy healthier lives.

Making Resources Go Further

Greater care coordination enables safety net providers across the spectrum of need to more efficiently and effectively use their resources, maximizing their ability to improve patient health outcomes and making limited resources go further to help more people in the community.

1. CAPH member public health care systems include county-owned and operated health care systems and University of California medical centers.

2. For more on the Medi-Cal 2020 waiver, visit caph.org/waiver.

Whole Person Care Pilots

California’s current five year Section 1115 Medicaid waiver² (known as Medi-Cal 2020) includes a \$3 billion pilot program to improve care for a subset of complex Medi-Cal beneficiaries by supporting local efforts that embrace the WPC philosophy.

Many local California communities, particularly at the county level, have already demonstrated the potential for integrated, patient-centered care through better coordination of physical and behavioral health and social services to help meet patients’ holistic needs, such as housing and food.

The Whole Person Care Pilot program represents a significant opportunity to scale, strengthen, and sustain these efforts in a meaningful way.

California’s public health care systems have been a driving force behind the creation of the WPC Pilot program, and in many counties will be leading local implementation efforts. This brief provides an overview of the WPC Pilot opportunity, as well as insights from public health care systems and their partners into the on-the-ground work ahead that will further advance Whole Person Care in California.

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ACHIEVING WHOLE PERSON CARE

At its core, the WPC Pilot is about building a better system of care for vulnerable individuals by breaking down the silos that exist between different health and social service programs and providers. Each WPC pilot will design and implement interventions to best suit the unique needs of its community, but all will be centered around these six elements:

1. Target Population

Identifying and serving a target population of particularly vulnerable Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes.

Public health care systems and their county partners have identified targeted subsets of complex patients within their overall Medi-Cal population who stand to benefit greatly from the WPC approach, such as people experiencing or at risk of homelessness; persons with serious mental illness, individuals transitioning back into the community after being incarcerated; and frequent users of the emergency room.

2. Collaborative Leadership

Creating a collaborative leadership structure headed by a group of public and private entities partnering together towards a common purpose.

Partners participating in a WPC pilot are collaborating to define and support a shared vision for the pilot and how they will achieve those aims.

“The Whole Person Care Pilot challenges county agencies, health plans, and service providers to think differently about how they work with one another and most importantly, to put patients at the center of that redesign. Regardless of the size of each pilot’s target population, these new ways of thinking and collaborating have the power to improve care in the safety net for all patients.”

— Brianna Lierman, Chief Executive Officer, Local Health Plans of California

3. Coordinating Services Across Sectors

Coordinating services across sectors to create a more effective and navigable experience for the target population, and to use resources more efficiently and effectively.

The WPC Pilot should spur improved coordination on two levels. First, at the individual level, the patients being served by the pilot must have their care coordinated across the services that they personally utilize and need. Second, at the systems level, the pilots’ lead and participating entities need to develop new and improved infrastructure and processes for communicating and working together in a more efficient and effective manner.

“The Whole Person Care Pilot Program gives California mental health plans and Medi-Cal managed care plans an unprecedented opportunity to build the underpinnings of care coordination and increase the integration of care for high-utilizing beneficiaries with mental illness in such a way that promotes recovery, wellness, and successful transitions to lower levels of care.”

—Kirsten Barlow, Executive Director, County Behavioral Health Directors Association of California

4. Sharing Data

Sharing data across partnering entities to increase coordination and appropriate access to care.

Many public health care systems believe data sharing to be the greatest area of challenge and opportunity for WPC pilots. Developing new data sharing capabilities will be critical for three main purposes: to identify the target population; coordinate care across sectors and service providers; and evaluate the impact of the pilots and meet the State’s reporting requirements.

SPOTLIGHT: Data Sharing for Whole Person Care in Ventura County

Ventura County Health Care Agency’s (VCHCA) WPC application targets Medi-Cal managed care beneficiaries who are the highest utilizers of emergency department and inpatient services. Ventura identified several factors that today prevent these individuals from consistently getting the right care at the right place at the right time, including siloed and potentially duplicative services, lack of communication between systems, lack of consistent data collection, and multiple, disjointed patient needs assessments. Efforts to integrate and share data will be a key strategy to address these barriers and ensure pilot success. Their WPC plans include:

- A web-based Care Coordination Platform that will provide the information needed to coordinate care across systems and conduct electronic referrals.
- A web-based Integrated Care Plan that will consolidate assessments and care plans from diverse system providers.
- A telemedicine consultation system for real-time secure messaging that will allow providers to share health information and collaborate to deliver care.
- A data warehouse that will be used to consolidate medical, behavioral and social services data for pilot monitoring, quality improvement, and reporting purposes.

5. Financial Flexibility

Investing in innovative infrastructure and providing services not otherwise paid for by the Medi-Cal program.

As WPC pilots assess the needs of their target population, they are likely to find that some of the infrastructure development, capacity building, services and supports needed are not paid for via existing funding streams. The flexible funding associated with the Pilot offers the opportunity to pay for these innovative investments and assess the return on investment to help advocate for future changes to how we spend existing and new funding.

6. Meeting Patient Needs

Providing the necessary care to meet the social, physical, and behavioral health needs of each targeted individual, to improve the overall health of the target population.

In some cases, the services needed may be available in the community and an approach of referral and coordination will suffice. In other cases, pilots will identify gaps in what is available and develop and deliver new service offerings.

SPOTLIGHT: A Holistic Approach to Care in Contra Costa County

Even before submitting a WPC application, Contra Costa Regional Medical Center and its system's Health Centers were already taking a Whole Person Care-like approach with targeted patients, through a program called Health Leads, connecting individuals and families with community organizations and resources they need to stay healthy.

For instance, "Maria" was a hospital patient who was seen regularly for a chronic cough and to recover from a recent surgery.

A patient advocate helped Maria identify three areas of concern for her family, and helped her find the help she needed through various community programs. She was able to obtain discounted transit services, assistance with her utility bills, and free food from two local organizations.

The advocate guided Maria and her two sons through navigating each process while developing a relationship with the family and helping ease their concerns about relying on these supports, ultimately ensuring that all their priority needs were met.

WHOLE PERSON CARE PILOTS

Pilot Selection Timeline

WPC pilot sites will be chosen based on a competitive application process overseen by the California Department of Health Care Services (DHCS). Applications to participate in the WPC Pilot were due to DHCS on July 1, 2016. Eighteen pilots submitted applications. Over the summer and fall, DHCS will review applications, and confer with CMS and applicants to arrive at its final selection of pilot sites by November 2016.

Local Partnerships

DHCS accepted WPC pilot applications from designated 'lead entities', which must be a county, a city and county, a health or hospital authority, a Designated Public Hospital, District/Municipal Public Hospital, a federally recognized tribe, a tribal health program operated under contract with the federal Indian Health Services, or a consortium of any of the above entities serving a county or region consisting of more than one county.

The lead entity will be the single point of contact for DHCS and is responsible for coordinating and monitoring the WPC pilot. The majority of lead entities who submitted applications were county health services agencies or public health care systems. In the WPC application, the lead entities described how they will work with a number of other key partners to implement the pilot, referred to as 'participating entities'.

Each WPC pilot must include the following participating entities:

- At least one Medi-Cal managed care health plan operating in the geographic area
- Both the health services and specialty mental health agency or department, and at least one other public agency or department, which may include county alcohol and substance use disorder programs, human services agencies, public health departments, criminal justice/probation entities, and housing authorities
- The public housing authority (if housing services are provided under the pilot)
- At least two other community partners that have significant experience serving the pilot's target population, including local physician groups, community clinics, hospitals, and community-based organizations

"There is a growing recognition that serving families and individuals based on this or that issue overlooks the entire picture of what is going on with them. Adding human services programs into the Whole Person Care discussions from the get-go is helping ensure that we really are thinking about each person in their entirety and bringing all the services we have to support them into play at the county level. That's why county human services directors have been glad to have a seat at the table locally to actively support Whole Person Care pilots."

—Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association of California

The first task for any pilot will be to identify one or more target populations, then look at how those patients are currently being served, in order to identify gaps in service delivery and opportunities for better coordination.

WPC pilots will determine the specific strategies they wish to employ and services they want to deliver, based upon the needs of their target populations. Local WPC collaborators will create stronger local service delivery infrastructures that will endure beyond the pilot, for example by sharing data and case conferencing.

Financing Structure

Medi-Cal 2020 provides up to \$1.5 billion in federal funding over five years, for selected pilots. As with all other waiver programs, since Medi-Cal is a state-federal partnership, in order to receive federal funds for the WPC pilots, a “non-federal” share, or source of matching funds, is required. In this program, the pilots will each individually provide the local matching funds through permissible sources of intergovernmental transfers (IGTs). Because California’s matching rate is 50 percent, the total non-federal share must also equal \$1.5 billion, for a total of up to \$3 billion.

The non-federal share must come from a public source of funds such as a county agency or public health care system. Local funds will be matched with federal funds and used by the pilot to support infrastructure such as cross-agency communication and data systems to facilitate better care coordination. Funds can also be used for services that Medi-Cal does not otherwise cover, such as medical respite, sobering centers, and tenancy supports for individuals at risk of or are experiencing homelessness.

Pilot Payments

Part of the impetus for the WPC Pilot is to expand the scope of services offered to meet patients’ needs. Often the most impactful interventions are not medical in nature, such as finding stable housing. The funds provided through the Pilot are meant to provide local flexibility, enabling smarter investment in patients and infrastructure that drive resources to core problems that will impact patient health outcomes and well-being, while reducing preventable inpatient and emergency room use.

WPC applications included a total requested annual dollar amount, which specifies payments for each element for which funding is requested, including: infrastructure, baseline data collection, interventions, and outcomes. The budgets are structured such that a specific dollar amount is linked in each year to specific deliverables, e.g., performance of specific activities, patient interventions, pay-for-reporting on metrics, and pay-for-performance tied to outcomes.

Pilots were able to request funding to provide discrete services to their enrolled populations, and could also choose to structure some of their WPC payments as per member per month (pmpm) service bundles. The bundled payment approach recognizes that a set of services is available to a particular target population, with actual utilization of each service within the bundle driven by what each individual needs and desires.

“Meeting the needs of the most vulnerable and overlooked Medicaid patients in our County requires program creativity and financial flexibility. Under Whole Person Care, the opportunity to build a distinct package of services for each target population, funded with a flexible per-enrollee bundled rate, allows each WPC pilot program to provide the right service at the right intensity and the right time. This is a dream come true for providers longing for new ways to serve a complex and sick population.”

—Mark Ghaly, M.D., Director, Community Health & Integrated Programs, Los Angeles County Department of Health Services

For pilots wishing to serve individuals at risk of or experiencing homelessness, WPC payments can support certain housing interventions and investments³, including:

- **Tenancy-based care management supports** to assist the target population in locating and maintaining medically necessary housing.
- **County Housing Pools.** WPC pilots may contribute to a county-wide housing pool that will directly provide needed support for medically necessary housing services, with the goal of improving access to housing. The Housing Pool may include funds that will be used for long-term housing costs, including rental subsidies; however, those are not eligible for federal matching funds through the WPC Pilot. The Housing Pool may also incorporate a financing component to reallocate or reinvest a portion of the savings from the reduced utilization of health care services into the Housing Pool.

3. WPC investments in housing units or housing subsidies, including any payment for room and board, are not eligible for Federal financial participation.

SPOTLIGHT: Chronically Homeless

For pilots targeting people who are homeless, services are likely to focus on helping enrollees find and secure housing. These “pre-tenancy” services include housing search assistance, working with landlords and affordable housing developers, connecting people to rental assistance and other benefits, helping to complete paperwork and obtain documentation, and assisting with move-in.

Once someone who was formerly chronically homeless moves into an apartment, they benefit from services to promote housing stability, also known as “tenancy sustaining services,” like help navigating relationships with landlords and neighbors, addressing behaviors that could lead to eviction, and providing education for life skills and money management.

WPC Pilot funding can pay for these services; build care coordinator and homeless service provider capacity; and even pay for one-time housing-related expenses, such as move-in costs or recuperative care for people exiting hospitals with nowhere to live.

“For people experiencing homelessness, housing is health care. Evidence shows people who remain homeless will continue to use health care inappropriately, and at high costs to our health systems, even if receiving well-coordinated care. Services for anyone experiencing homelessness should begin with intensive, face-to-face engagement and housing navigation services, and then work to keep people stably housed.”

—Sharon Rapport, Associate Director, California Policy, Corporation for Supportive Housing

Measuring Success

The WPC Pilot includes several performance metrics to monitor progress within and across the pilot sites. All pilot sites will report on a standardized set of performance measures, known as ‘universal metrics’. Each pilot has also chosen additional measures tailored to its unique target population and strategies, known as “variant metrics”.

Pilots will utilize the quality improvement approach known as “Plan Do Study Act” (PDSA) to continually monitor and improve on their universal and variant metrics throughout the pilot period.

Universal Metrics: Health Care Utilization

Ambulatory Care - Emergency Department Visits

Inpatient Utilization - General Hospital/Acute Care

Follow-up After Hospitalization for Mental Illness

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Universal Metrics: Care Process & Infrastructure

Pilots must demonstrate care coordination, case management, and referral policies and procedures across the WPC pilot lead and all participating entities that provide streamlined care for WPC patients.

Pilots must demonstrate data and information sharing policies and procedures across the WPC pilot lead and all participating entities that provide streamlined care coordination, case management, monitoring, and strategic improvements.

Formal Evaluation

These metrics will help the State evaluate the overall success of the WPC Pilot. A formal evaluation will be conducted to understand the extent to which the WPC pilots:

Improve coordination across participating entities including data and information sharing

Improve beneficiary health outcomes

Reduce avoidable utilization of emergency and inpatient services

Increase access to social services

Improve care coordination across participating entities

Improve housing stability

SPOTLIGHT: San Francisco’s Proposed Whole Person Care Pilot

Despite a long and proud history of providing compassionate care, supportive housing and other services, homelessness remains a chronic condition for far too many on San Francisco’s streets. Data shows that many among this group also suffer poor physical and mental health, and touch multiple systems across the city. While the city has often been an example of providing innovative services, including being one of the first counties to look at homelessness as a system-wide issue, a long-standing challenge has been the real time coordination of services across agencies.

The WPC Pilot will be critical in helping San Francisco take the next step of strategic collaboration across City systems. Led by the Department of Public Health and developed in collaboration with many partnering entities, San Francisco’s WPC Pilot seeks to fill gaps in the current system and build infrastructure that will improve how the city cares for its most vulnerable in the long term.

Innovations in Infrastructure

A Multi-Agency Care Coordination System will:

- Establish a data sharing platform that can be used as both a real-time care management tool that links information across agencies and disciplines and an integrated data system for analysis and monitoring
- Develop and implement a multi-agency universal assessment tool to evaluate the needs of each homeless San Franciscan
- Use data to strengthen care coordination by stratifying the population based on risk and prioritizing those with the greatest needs for the deepest interventions
- Provide a foundation for a city-wide Navigation System, which aligns shelter and housing resources and creates system-wide priorities and data to match people in need with the right housing intervention

Innovations in Service

Focusing on 6,700 homeless adults who rely on the public health care safety net, innovative service interventions will:

- Maximize use of existing services; and
- Create new services that fill identified gaps, largely in the area of behavioral health. For example, embedding substance use counselors in primary care and mental health clinics, and expanding access to residential substance use treatment.

Complementing Other Waiver Initiatives

Public health care systems are embarking upon the WPC pilots while also participating in other delivery system transformation opportunities through the Medi-Cal 2020 waiver. While the programs are distinct, the strategies are inter-connected and complement one another to further strengthen the public health care safety net and improve the health of patients served by those systems.

PRIME

Public Hospital Incentives and Redesign in Medi-Cal (PRIME) is a pay-for-performance program that allows public health care systems to use evidence-based quality improvement methods to achieve ambitious, year-over-year performance targets. Federal incentive payments are contingent upon meeting these targets. PRIME features projects that focus on improvements in ambulatory care, high-risk populations, and efforts to improve patient care and efficiency—projects that can catalyze WPC Pilot success. Through PRIME, each public health care system will be transforming its outpatient delivery system and providing care management for high risk patients.

Global Payment Program

The Global Payment Program (GPP) is a first-in-the-nation payment reform program that creates incentives for county-owned and operated public health care systems in California to provide care to the remaining uninsured in more appropriate settings, such as primary care clinics. The GPP lifts restrictions that have historically impeded providing services for the uninsured in outpatient settings. The program also offers reimbursement for non-traditional methods of care delivery that have not previously been covered, such as health coaching and phone visits. While the target populations of GPP and WPC are different, WPC pilots will also be seeking to deliver non-traditional services to fill the gaps that exist between what systems offer today and what pilot enrollees truly need and want to help them get well and stay healthy. As more and more programs and funding streams support this kind of innovation, non-traditional services will become part of the basic fabric of health care delivery in California's safety net, giving millions of patients access to more patient-centered care.

Dental Transformation Initiative

The Dental Transformation Initiative (DTI) offers incentive payments to dental providers and creates a local pilot opportunity to improve dental health for Medi-Cal children. More specifically, this program aims to increase the use of preventive dental services, prevent and treat more early childhood cavities, and increase continuity of care so Medi-Cal children have a consistent dental health home. Given that access to high-quality oral health care is a critical ingredient for whole person health, the improvements made as a result of the DTI will help California achieve overall better health outcomes for Medi-Cal beneficiaries.

For more on the Medi-Cal 2020 waiver, visit caph.org/waiver.

LOOKING AHEAD

Successful implementation of the WPC Pilot over the next four years will identify and test new ways to bridge the silos entrenched in California's safety net delivery system, with the potential to spread lessons learned and best practices throughout the state and country. California again has an opportunity to lead the nation in innovative ways to improve care for patients who deserve a seamless system that meets their needs and helps them live healthy, productive lives.

“Whole Person Care speaks to the very core of our safety net mission: to lift up our most vulnerable and change communities for the better, one life at a time.”

--Erica Murray, President and CEO, CAPH

ABOUT CAPH/SNI

The California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI) represent California's 21 public health care systems and academic medical centers.

As a trade association, CAPH works to advance policy and advocacy efforts that strengthen the capacity of its members to ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians, and educate the next generation of health care professionals.

SNI, a 501c3 affiliate of CAPH, designs and directs programs that accelerate the spread of innovative practices among public health care systems, public clinics, and beyond. SNI's work informs CAPH's policy and advocacy efforts, and helps these providers deliver more effective, efficient and patient-centered health care to the communities they serve.

ABOUT CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

Serving more than 40 percent of the state's remaining uninsured and 25 percent of its Medi-Cal population, California's 21 public health care systems operate in fifteen counties where more than three quarters of the state's population lives.

Though just 6 percent of all health care systems in the state, they serve more than 2.85 million patients a year, provide 10.5 million outpatient visits annually, operate more than half of the state's top-level trauma and burn centers, and train more than half of all new doctors in the state.