Opportunities for Whole-Person Care in California

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Prepared by John Snow, Inc.,
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As a non-profit trade organization representing California's public health care systems, CAPH works to strengthen the capacity of its member health care systems to advance community health; ensure access to comprehensive, high quality, culturally sensitive health care services for all Californians; and educate the next generation of health care professionals. SNI is the quality improvement, transformation and research partner of CAPH, designing and directing programs that accelerate the spread of innovative practices among California's public hospitals, public clinics and beyond.

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Introduction

Low-income, vulnerable individuals often have unmet health service and behavioral health needs; furthermore, these individuals often experience challenging social and economic issues, such as housing instability, unemployment, and food insecurity, that can cause, exacerbate, and complicate the treatment of health conditions, leading to unfair and avoidable differences in health status.[1,2] When health issues then arise, it is often in a fragmented, fee-for-service health system that can be difficult to navigate, and which does not consistently coordinate with the behavioral health system and social services systems that may be serving the same individuals. While the need to better coordinate services has been long recognized, progress has been challenging due in part to the fragmented nature of the organizational structures and financing of our current healthcare and human services systems. The result is that vulnerable individuals who have the greatest health, behavioral health, and social service needs often find themselves having to navigate systems that have different structures and practices, programmatic goals and financial incentives.

In order to achieve the Triple Aim[3] of improving health outcomes, reducing per capita costs and improving patient experience within the safety net, it will be necessary to employ new philosophies and practices. Part of the solution lies in improved coordination of care within and across systems. It is also necessary to better account for and address the conditions that shape health in the environments where people live, work, and play.[4] These conditions are frequently referred to as the "social determinants of health," and addressing them has often been considered the purview of policymakers and non-health sectors (e.g., housing, economic development, education). However, there is increasing interest and attention focused on the potential to address social determinants in a clinical context at the individual and service system levels while policy efforts continue at the community level.[5] In a prior paper, written as part of this Blue Shield of California Foundation (BSCF) project, we proposed a "whole-person care" framework to approach the challenge of addressing vulnerable individuals' health, behavioral health, and social needs in concert rather than in isolation.

We define "Whole-Person Care" as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.[6] By reducing duplication of effort and more efficiently addressing patient needs, a whole-person care approach could make great strides toward achieving the Triple Aim for Medicaid and safety-net populations and could have positive impact in other publicly financed systems such as behavioral health, social services, education, and public safety. In California, the State, counties, statewide associations and foundations, and community-based organizations are contributing to a growing national conversation about how to better address health, behavioral health, and social needs through a "whole-person" strategy that is focused on improving outcomes for individuals and populations, while reducing costs across public systems.

Recent policy changes in California make the present an opportune time to advance whole-person care. In particular, national and state-level changes are creating a new landscape for California counties and local service providers to consider how to provide whole-person care in a new policy environment marked by the Medi-Cal expansion, expanded substance use disorder coverage under Medi-Cal, restructured financing for county health and human services, an expanded role for Medi-Cal health plans for provision of mental health services, and the largest dual-eligible demonstration in the country. In fact, California's dual-eligible demonstration—the Coordinated Care Initiative—represents a paramount example of the State of California implementing a whole-person care initiative: blended financing for individuals dually eligible for Medicare and Medicaid has the clear intent of better coordination of care for these vulnerable individuals and an end goal of meeting the Triple Aim.[7] Table 2 shows an overview of key policy changes that together create a policy environment that lays a robust foundation for state and county leaders in California to advance whole-person care strategies. The need for more coordination across sectors and whole-person care is also gaining the attention of leaders across the California policy and political landscape, as evidenced by the DHCS Initial Concepts for 2015 Waiver Paper released in July 2014 and California's State Innovation Model application submitted in July 2014.[8]

Purpose of Paper

With the generous support of Blue Shield of California Foundation, this White Paper is the second of two papers that seek to identify policy recommendations and next steps for advancing whole-person care for California's vulnerable populations. The impetus for both papers stems from a growing interest in linking social services, behavioral health, and healthcare delivery transformation in the safety net. The objectives of this paper are to:

I. Summarize the need and opportunity for whole-person care;
II. Utilize a framework of six key dimensions of whole-person care (Figure 1) to analyze findings regarding whole-person care related activities, opportunities, and challenges based on interviews in five California counties; and
III. Identify opportunities for county-level safety-net stakeholders (including county leaders

in hospitals and health systems, behavioral health, social services, community-based organizations and providers, and managed care organizations), state-level organizations and foundations, and California state policymakers to consider for improved coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.

Methodology

Whole-Person Care Framework Development

With the support of BSCF and in collaboration with partners at California Association of Public Hospitals and Health Systems (CAPH) and the Safety-Net Institute (SNI), John Snow, Inc. (JSI) set out on a year-long endeavor to create a whole-person care framework and to understand the feasibility of implementing whole-person care in California. JSI reviewed national literature and spoke with thought leaders in California and other states, and conducted 36 individual and three group interviews between December 2013 and June 2014 with administrative leaders and providers from the health, behavioral health, and social service sectors in five California counties: Los Angeles, San Diego, San Mateo, Santa Clara, and Sonoma.

Figure 1. Dimensions of Whole-Person Care

In March 2014, JSI, in collaboration with SNI, published a White Paper titled "National Approaches to Whole-Person Care in the Safety Net,"[9] which explored notable approaches employed across the country for coordinating health, behavioral health, and social services in a patient-centered manner. In that paper, JSI outlined six dimensions of whole-person care based on a review of a growing body of literature and primary research on the safety net in California and other states. The six dimensions of whole-person care – collaborative leadership, target population, patient-centered care, collaboration across sectors, shared data, and financial flexibility – serve as a framework for the recommendations provided in this paper, and are summarized in Figure 1 and Table 1.

Figure 1 displays the dimensions of whole-person care in an overlapping circular pattern because our discussions with stakeholders revealed that while all elements were considered important to consider, the implementation of a whole-person care strategy is not necessarily a linear process. Different counties might choose to start with a focus on different elements, depending on prior efforts and challenges.

County Selection

The five counties in California chosen for this study were selected because they represented both Northern and Southern California; rural, urban and suburban environments; County-Operated Health System (COHS), two-plan, and Geographic Managed Care Medi-Cal managed care models; provider, payer and hybrid counties; and public hospital and non-public hospital counties. Interviewees from each county included key leadership, administrative, financial, and clinical staff from public hospital systems, community health centers, behavioral health providers, health plans, and county social service agencies. While we would have liked to conduct similar conversations in additional counties, time and resource constraints limited the project to a stratified sample. In the course of our conversations, interviewees frequently cited whole-person care efforts in other California counties, and state-level key informants and thought leaders also pointed out that conducting similar conversations in counties beyond the five sampled could be a potentially beneficial extension of this work.

Analysis

JSI qualitatively analyzed the interviews in the five California counties for key themes and opportunities. The findings and recommendations are supplemented with insights gathered by the JSI research team over the past three years from multiple projects focused on payment reform and delivery system transformation with an emphasis on safety-net populations; such projects have included interviews with state officials and representatives of emerging accountable care organizations and innovative delivery and payment reform initiatives in Alabama, California, Colorado, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Jersey, North Carolina, Oregon, Pennsylvania, Vermont, and Washington. The analysis is also rooted in a review of published articles and gray literature on delivery system transformation models that touch on whole-person care concepts.

Advisory Committee

We established an Advisory Committee (see Appendix A) of seven safety-net thought leaders spanning the county, state, and local levels. We selected members to represent the public sectors that would be studied during this project, such as health, mental health, social services, and county government. We also included an expert in Medicaid populations and housing. Interviews with Advisory Committee members provided county and state-level insights into California's safety-net policy environment as well as advice on the selection of counties. The Advisory Committee also provided feedback on a draft of this document.

Table 1. Dimensions of Whole-Person Care[38]

Dimension	Definition
Collaborative Leadership	• Leadership can create a unifying vision for system transformation and must be present at multiple levels within the health and human services systems • Strong leadership can galvanize time, energy, and resources to identify priority populations and share data; shape a vision for care that addresses social determinants of health; make a compelling case for financial flexibility; and foster and maintain relationships across entities that may not have traditionally collaborated
Target Population	• Identification of a target population is a key starting point for the implementation of whole-person care • In a narrow approach, service model is targeted to a small high-cost, high-risk sub-population • In a population approach, the service model is applied to an entire population at the county or sub-county level

Patient-Centered Care	• Patient-centered care is care that is tailored to the individual, taking into account the complex constellation of social, behavioral, and physical health needs a vulnerable individual has in a consumer-centric manner
	• Emerging commonalities across systems to delivering patient-centered care are:
	  • Multiple providers are working with an individual to develop an individualized care plan that takes into account the patient's goals, motivations, and needs across multiple systems
	  • Individuals may have a designated care manager or care coordinator to support the implementation of the care plan, connect the patient to appropriate services, monitor progress towards care plan goals, and adjust interventions as needed

Coordination of Care Across Sectors	• Coordination between multiple providers and agencies serving a single individual is the key goal in a whole-person care model • Coordination is achieved through integration and/or collaboration between discrete entities that have distinct leaders, goals, budgets, staff • Integration means that services are delivered by a single organization, at times in a single location most appropriate for an individual's care
Shared Data	• Due to the siloed nature of health, behavioral health, and social service systems, as well as privacy laws and concerns, each system typically has its own data system, including information that cannot be shared between providers or across sectors • Four major spheres of data can be shared: eligibility, health, behavioral health (including mental health and substance use), and social services (including utilization of county services and community-based social services such as housing) • Shared data across sectors could help in providing whole-person by 1) Targeting high-need individuals with specific patient-centered interventions; 2) Allowing for coordinating services in real time across entities: and 3) Supporting payment reforms and evaluation of whole-person care delivery system reforms
Financial Flexibility	• Public financing for health, behavioral health, public health, and social services are currently siloed funding streams • Financial flexibility can support and enhance whole-person care by allowing providers to spend funds flexibly to meet individuals' needs rather than funding requirements of public payers • Blended funding and braided funding are the primary mechanisms used to create financial flexibility. Blended funding refers to when two agencies at any level (e.g., county, state, federal) agree to jointly fund a set of services, and the funds are pooled into a single payment to organizations responsible for delivering or contracting for the delivery of services. Braided funding refers to two or more agencies jointly paying for a package of services but the funding stream and reporting requirements remain separate.

Background: The Need for Whole-Person Care

As the Triple Aim framework becomes firmly established in shaping and guiding health care reform efforts, there is increasing interest in addressing the social determinants of health that play a profound role in the health of individuals and communities, particularly for low-income populations served by public healthcare systems and safety-net providers. Such providers recognize that models of care must take into account the complex array of social and environmental factors that overlap with health issues for any individual, impacting service utilization, health outcomes, and access to services. For example, unmet social needs associated with poverty—such as unstable housing, unemployment, food insecurity, and lack of transportation—serve as stressors and structural barriers and diminish an individual's ability to access services and comply with self-management plans. Providers serving low-income safety-net populations increasingly wish they "could prescribe remedies" to common unmet social needs, such as housing instability, as a key strategy for helping patients to achieve health outcomes.[10] Furthermore, in recent policy discussions, there is growing agreement that considering social determinants of health concurrently with health and behavioral health conditions is critical to both achieving Triple Aim goals and reducing health disparities in communities.[11, 12, 13, 14, 15]

The Need for Whole-Person Care

The need for whole-person care stems from unmet social, behavioral health, and health needs within vulnerable populations, and from fragmentation of organization and financing of current health and human services systems. Indeed, safety-net populations are more likely to experience a multitude of health, behavioral health, and social needs, requiring navigating care across multiple and fragmented systems. For example, the prevalence of mental illness among Medicaid beneficiaries is twice that of the general population, and nearly half of beneficiaries with disabilities have a psychiatric illness.[16,17] Research also shows that individuals with serious mental illness (SMI) are at a greater risk of death, have lower life expectancy by nearly 25 years, and are more likely to have

chronic medical conditions compared to the general population. Medicaid beneficiaries with SMI also have significantly higher medical costs than those without SMI.[a]

Within the safety net, homeless individuals and those in the justice system are particularly vulnerable and frequently have concurrent health, behavioral health, and social service needs. For example, the chronically homeless are likely to experience multiple co-occurring issues, including health and mental health conditions as well substance use disorders. In fact, nearly half (46%) of the sheltered homeless are estimated to have serious mental illness (SMI) and/or substance use disorders.[18,19] Similarly, 70 percent of youth in juvenile justice systems have at least one mental health condition, and at least 20 percent live with a severe mental illness. Approximately 20 percent of state prisoners and 21 percent of local jail prisoners have "a recent history" of a mental health condition.[20] In California, the challenge of addressing co-occurring mental health and substance use disorder needs is complicated by the complex financing and service delivery system for individuals suffering from SMI and/or substance use disorders that has been documented in compelling detail elsewhere.[21]

The issue of unstable housing and homelessness[b] and its influence on the health system, is a national challenge, with particular significance in California. California is home to 36 percent of the chronically homeless population in the country and has the highest rate of unsheltered homeless and chronically homeless nationally.[22] Providing supportive housing with integrated health and social services to high-cost individuals (often with comorbid physical and mental health conditions) has been shown to reduce healthcare costs and utilization significantly.[23,24] While Medicaid does fund services that are part of supportive housing—particularly for individuals with SMI and disabilities—broadly speaking, Medicaid funds have not been authorized for direct payment for housing, even in cases when funding housing might prevent hospitalization. The interest and potential impact in coming up with new, innovative approaches to this issue is evidenced by California's recent 1115 waiver proposal to allow Medi-Cal funds to be used for shelter.[c]

In addition to the prevalence of psychosocial and behavioral issues that need to be addressed in concert with health concerns among low-income and vulnerable populations, the need for whole-person care is evident at the patient, provider, and system levels. From a patient perspective, the need for whole-person care centers on the current experience of navigating and interacting with multiple uncoordinated systems. Even if health, behavioral health, and social services are individually functioning as "cylinders of excellence,"[25] the experience can feel overwhelming and confusing for a patient interacting with uncoordinated systems, as he or she might receive mixed

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a 11% of Medicaid FFS beneficiaries have serious mental illness (SMI) but account for 39% of Medicaid FFS costs. Source: Jarvis, D. Presentation at Sonoma Behavioral Health Summit. Sonoma, CA. December 13, 2013.

b There are multiple definitions of homelessness and unstable housing. For more information, see the National Healthcare for the Homeless Council: http://www.nhchc.org/faq/official-definition-homelessness/

c In State conference call addressing the State 1115 Waiver Concept paper, DHCS made no distinction between the definitions of "shelter" and housing.

messages from multiple providers, and potentially from more than one care manager. At the health provider level, lack of attention to an individual's social and behavioral health needs can result in less than optimal quality outcomes, potentially duplicated services, and inefficient use of health system resources, such as high emergency-department utilization and other costly and avoidable care.[26] At the system level, multiple state or county agencies may be simultaneously identifying and intervening with the same high-need individuals but not coordinating services, resulting in less than optimal outcomes for vulnerable individuals and less than optimal use of scarce public resources.

The Opportunity

In this White Paper and the former paper written for this project, we posit that expanding the notion of integration beyond the health sector to include coordination of a broad range of health, behavioral health, and social services holds the most promise for achieving the Triple Aim in Medicaid while also reducing health disparities and optimizing use of public resources.[27] **Based on our conversations nationally and in California with public sector leaders, the notion of whole-person care can be readily applied to a broad range of potential target populations and contexts, wherever there are socioeconomic and behavioral factors that influence health outcomes, health-system utilization and use of other public resources.** However, the opportunity for whole-person care in California is especially relevant at this moment in time because of a confluence of policy changes (summarized in Table 2) and concordance in state and county-level commitment to and strategies for achieving the Triple Aim in Medi-Cal.

The Affordable Care Act (ACA) has provided a significant opportunity to provide whole-person care for people who previously were uninsured or underinsured. Due to policy change providing new entitlement to Medicaid and expanding mental health and substance-use Medicaid benefits, providers have the opportunity to better coordinate care and receive a stable source of payment for these patients. The California Legislative Analyst's Office estimates that the Medi-Cal expansion will attract approximately $8.9 billion in additional federal funding to the state in 2014-15. Medi-Cal managed care organizations will receive much of this funding, as will providers who care for Medi-Cal and uninsured populations. As mentioned previously, California has also already introduced important financial flexibility through managed care Medi-Cal in blending Medicare and Medicaid funding in the Coordinated Care Initiative (CCI). Where prior fragmentation of Medicare and Medicaid funding created a disincentive for Medicaid to invest in strategies that would only result in savings to Medicare, blending the funding streams creates a novel landscape of incentives and resources that allow managed care Medi-Cal plans to coordinate care and reap financial rewards if coordination strategies prevent unnecessary hospitalizations for dual-eligible individuals.

> *"… the Medicaid expansion creates both fiscal and programmatic opportunities … a sea change in the health and human services system – it will make Medi-Cal the common denominator for the low-income population."*
>
> *– Phil Ansell, Assistant Director, LA County Department of Public Social Services*

Furthermore, the opportunity for interagency collaboration at the individual county level is complimented by recent demonstrations of state-level vision for policy initiatives that could support whole-person care. For example, in July 2014, the State of California submitted a State Innovation Models (SIM) grant application to the Center for Medicare and Medicaid Innovations as a step toward implementing the state's Health Innovation Plan.[28] It is notable that the SIM grant contains both a health home initiative and an Accountable Community for Health initiative, both of which could support whole-person care efforts for narrow and/or broad target populations. 2014-15 will also see the shaping of California's next Medicaid 1115 waiver and discussion regarding other future options, such as the 1915(c) waiver and 1915(i) state plan amendment options that address Home and Community-Based Services (HCBS). The DHCS "Initial Concepts for 2015" Waiver Paper released in July 2014 offers numerous ideas that align with many of the findings and recommendations that emerged from our 36 key informant interviews conducted in five California counties between December 2013 and June 2014, including but not limited to the need for payment reforms that create financial flexibility and innovative ways to fund housing for high-risk Medicaid populations. Finally, as detailed in Table 2, recent expansions in the Drug Medi-Cal benefit, a proposed Drug Medi-Cal waiver, and mental health responsibility for managed care Medi-Cal plans also set a new stage for considering how to best coordinate behavioral health and health services. Indeed, the evolving policy landscape and the concordance in thinking among state and county-level thought leaders creates a fertile ground for both state and local action to advance whole-person care in California.

Despite these opportunities, it is important to note that ACA-prompted changes have created some degree of financial uncertainty for public healthcare systems and other providers predominantly focused on how to sustain an effective safety-net system for California's estimated 3-4 million residual uninsured while also meeting potential increased demand for services from the newly insured. For example, reductions in Disproportionate Share Hospitals (DSH) payments, the 2013 Health Realignment of indigent care funds from counties back to the state, and the expanded enrollment of previously ineligible Medi-Cal patients create a dynamic set of new financial flows between the counties and the state. Nevertheless, within the context of this dynamic environment, stakeholders recognize that there are new opportunities for safety-net providers and counties to develop coordinated services across multiple county agencies and other community organizations as part of a whole-person care strategy for achieving the Triple Aim for California's vulnerable populations.

Table 2. Recent Policy Changes in California[39-45]

Policy	Signficance and Impact
The Patient Protection and Affordable Care Act (2010), including the Medi-Cal Expansion (effective January 2014)	The Affordable Care Act has served as a catalyst for health care reform at the state and county levels in California with the expansion of healthcare coverage for low-income individuals through Medi-Cal and Covered California, simplified enrollment processes for Medi-Cal, and new requirements that health plans offer comprehensive benefits packages. • With the expansion of Medi-Cal to adults up to 138% of the Federal Poverty Level, California is estimated to gain an additional 1-2 million beneficiaries in the Medi-Cal program (for approximately 11 million total covered by Medi-Cal) after January 2014. Enrollment as of May 2014 was at 10.6 million for Medi-Cal and CHIP. • The ACA also requires Medi-Cal to meet federal requirements for mental health parity, meaning that mental health and substance use disorders are covered under the Medi-Cal Essential Benefits package.
Expansion of Managed Care Across the State	Medi-Cal beneficiaries who are children or parents are required to enroll in a managed care plan if available in their county. In 2011, this requirement was expanded to include seniors and people with disabilities (excluding dual eligibles), first to 14 selected counties. All Medi-Cal expansion populations will also be required to enroll in managed care plans.
Coordinated Care Initiative	The Coordinated Care Initiative (passed in 2012) creates new opportunities for improved integration of health, behavioral health, and long-term supports and services (LTSS) for low-income seniors, persons with disabilities, and dual eligible beneficiaries and served to authorize CA to participate in the federal duals demonstration project. Starting in 8 counties in 2014, CalMediConnect (the duals 3-year demonstration in California) will cover up to 456,000 beneficiaries with blended Medicare/Medicaid funding provided to managed care plans. The second part of CCI requires all remaining Medi-Cal beneficiaries (including duals who do not enroll in CalMediConnect, who were excluded from the previous managed care expansions) to enroll in a Medicaid managed care plan. The CCI also integrates LTSS services as a Medi-Cal managed care benefit for all Medicare-Medicaid enrollees as well as Medi-Cal-only seniors and persons with disabilities residing in the Demonstration counties.
Expansion of Drug Medi-Cal Benefits	Effective January 1, 2014, Medi-Cal benefit coverage was expanded to provide additional substance use disorder services to Medi-Cal beneficiaries: • Voluntary Inpatient Detoxification • Intensive Outpatient Treatment Services • Residential Treatment Services • Outpatient Drug Free Services • Narcotic Treatment Services
California Assembly Bill 109 (AB109): Public Safety Realignment of 2011	The Public Safety Realignment of 2011 (AB109 and companion bill AB117) transferred responsibility for specific prison populations (i.e. select types of non-violent, non-serious, non-sex felony crime offenders) from the State prison system (e.g. state prisons and parole officers) to county jails and probation officers, making counties responsible for jail inmates and for post-release supervision of parolees. Under other recent legislation, jail inmates may be determined eligible for Medi-Cal coverage of inpatient hospital services provided in a community hospital and may also apply for Medi-Cal while incarcerated, although Medi-Cal enrollment may take effect only upon their release from incarceration.
Delineation of responsibility for Medi-Cal mental health services by counties and managed care plans	In Medi-Cal, County mental health departments have responsibility for specialty mental health services for those individuals with serious and persistent mental illness. Effective January 1, 2014, Medi-Cal managed care plans were given responsibility for the provision of mild-to-moderate mental health services, including: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Psychiatric consultation

Key Findings: Whole-Person Care in Select California Counties

Two overarching findings emerged as we applied the proposed whole-person care framework in the context of interviews and analysis. First, interviewees found the framework itself sufficiently comprehensive for approaching the large concept of whole-person care and useful for breaking down the whole-person care concept into discrete areas of challenge and opportunity. Second, while the framework was helpful for analyzing key themes and findings from the county interviews, the opportunities identified often tended to stretch across framework dimensions. As a consequence, we have organized the findings not by dimension, but into opportunities identified by the group for next steps in advancing whole-person care.

"Whole-person care means that you… connect the person to multiple solutions—including warm handoffs, connecting people with peers, serving them where they have trusted relationships … connecting them with social services from a medical home, or connecting them to community-based care from a church."

– Dale Fleming, Deputy Director, Office of Strategy & Innovation, San Diego Health & Human Services Agency

Collaborative Leadership

Collaborative county leadership was cited repeatedly as a foundational component for developing, adopting, and implementing a whole-person care strategy among county agencies and local stakeholders for serving vulnerable and at-risk populations requiring or seeking services across two or more sectors. Specific findings related to collaborative leadership included:

- **Aligning health, behavioral health, and social services interests and establishing shared goals and accountability is more important than ever before.** Eligibility and enrollment in Medi-Cal are not only critical to access health services, substance use disorder

services, and mental health care for people with mild to moderate mental health disorders, but Medi-Cal enrollment is also the moment when clients are assessed for eligibility and connected to other social service programs. Interviewees noted eligibility processing time and "closing the referral loop" as two areas where leaders could establish shared performance goals.

- **Political will plays a pivotal role in creating traction for cross-sector collaboration.** Interviewees frequently pointed to well-supported programs targeting discrete populations with whole-person care services as having champions at the highest levels of county executive and county supervisor leadership. Whether it was San Diego County's broad population LiveWell strategy, Los Angeles County's innovations in supportive housing for individuals with severe medical and housing needs, or focused coordinated care efforts for chronically homeless individuals in Santa Clara County, support at the highest leadership levels was instrumental in advancing whole-person care initiatives. Table 3 identifies a range of county-level examples of cross-sector collaboration for whole-person care.

> *"The relationships and the leadership is really important… There's a whole world of services and agencies that plans have been siloed from such that planning together as a community is important."*
>
> *– Maya Altman, CEO*
> *Health Plan of San Mateo*

- **Leadership at multiple levels of organizations is required for effective implementation.** Interviewees consistently cited that support at the county executive and county board level is extremely helpful for creating vision and catalyzing action. At the same time, interviewees also reflected on the equal importance of having ongoing communication and collaboration between leaders at the agency level, the delivery-system level, mid-level management, and the unit-based team level when it comes to implementing and sustaining change.

- **Relationships between people ultimately form the substance of coordination of services, and relationships take time and energy to foster.** We heard multiple stakeholders recount that "co-location does not equal coordination," and that true coordination between providers has been hard won through sustained efforts in bringing people together. Examples include Sonoma County hosting a summit on Integrated Behavioral Health, San Mateo County leaders from multiple sectors meeting regularly, Los Angeles County's emerging efforts to establish a Health Neighborhood for individuals in the county Mental Health system, San Diego's county-hosted summit meetings that forged relationships between substance use, mental health, and primary care providers and Santa Clara County's efforts in building relationships between primary care and mental health providers as mental health services were integrated in county FQHCs.

- **Collaborative leadership can originate from a variety of entities.** Furthermore, collaborative leadership looks different in public hospital and non-public hospital counties and in COHS vs. non-COHS counties. Payers, including public health plans and counties themselves, recognized their ability to leverage their role to promote collaboration between service providers and across sectors with financial incentives. In San Mateo County's case as a single-plan COHS county, the plan was a natural lead for driving cross-county conversations regarding the Coordinated Care Initiative. Providers also viewed themselves as catalytic agents for elevating the need for whole-person care and inviting other sectors to collaborate in whole-person care efforts. The hospital/health system tended to function as a lead entity in whole-person care efforts in public-hospital counties with whom we spoke, whereas the FQHC coalitions frequently assumed leadership roles in whole-person care efforts in non-public hospital counties. For instance, Redwood Community Health Coalition in Sonoma County has been a leader in grant efforts to better coordinate care for individuals with co-occurring mental health and substance use, and San Diego Council of Community Clinics and the county played significant lead roles in crafting a pivotal pay-for-performance program in the county's early Medicaid expansion Low-Income Health Program (LIHP). San Diego County has also galvanized collaboration among safety-net health and behavioral service providers. Ultimately, regardless of where the impetus originates, a critical factor for whole-person care efforts was that leaders across multiple sectors viewed themselves as partners in achieving shared goals that could only be achieved with communication and collaboration across sectors.

> *"[There are] lots of different ways we build trust with different sectors. For example, we work together on task forces, teams, collaboratives, boards, where we get to know each other in regular meetings."*
>
> *- Elisabeth Chichoine, Director of Public Health Nursing*
> *Sonoma County Department of Public Health*

Target Population

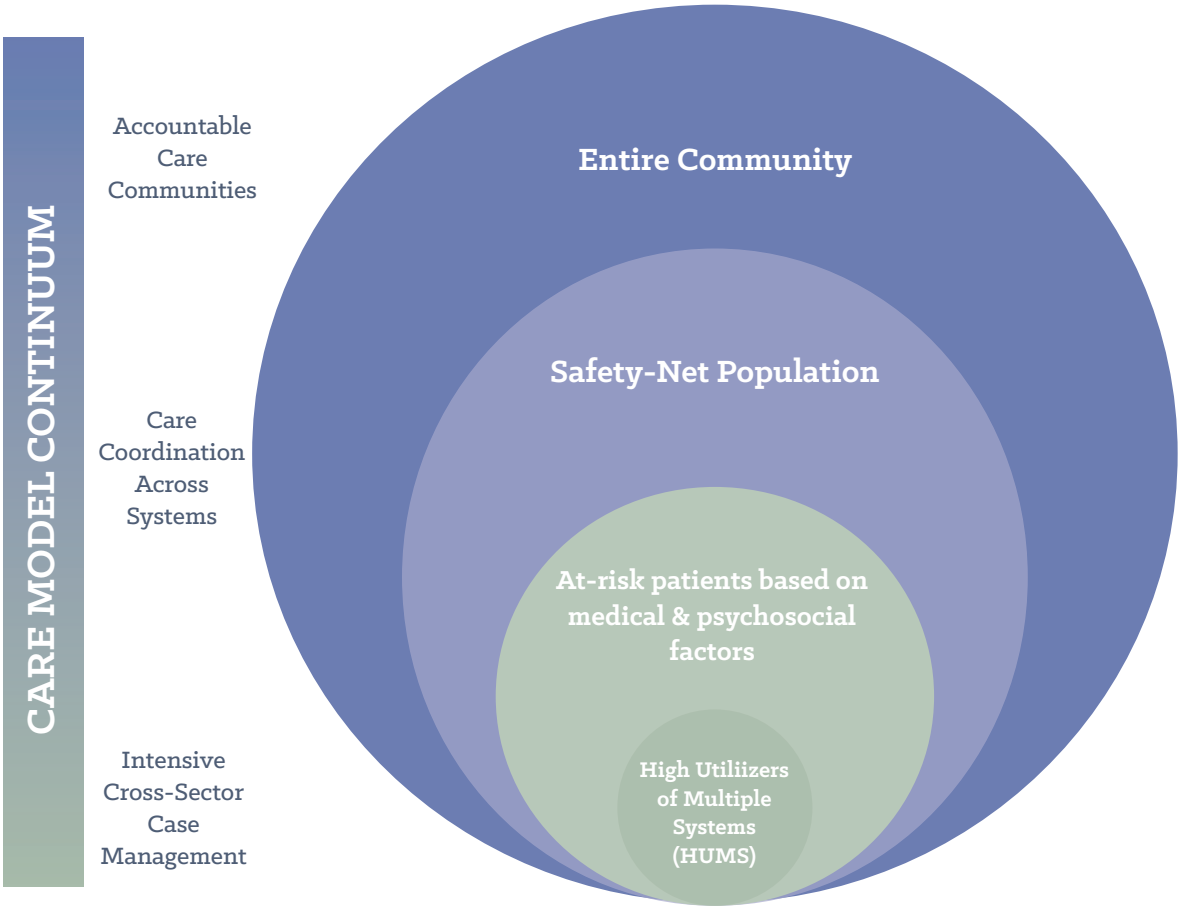
The whole-person care framework emerges from a vision of coordinating health, behavioral health and social services in a fashion that considers, and in some cases directly addresses, an individual's social determinants of health as a strategy for achieving the Triple Aim for safety-net populations. For some interviewees, the target population for whole-person care applies to all low-income populations. For many interviewees, the most immediate opportunity resides in a focus on individuals who are high utilizers of multiple systems (HUMS). Counties acknowledge that multiple county agencies are often serving the same patients/clients, with significant overlap among the highest utilizers. County leaders from multiple agencies viewed the need for better coordination for these individuals across sectors and expressed that working together to treat individuals as one person rather than separate patients/clients would be beneficial to the individual and the systems. Finally, many stakeholders articulated that opportunity lies in expanding the target population for whole-person care strategies beyond just the individuals with highest utilization of systems to individuals at high-risk. The key insights on target population from our interviews revealed the following:

- **Some counties have started to take a whole-person care approach for some discrete, high-risk subpopulations.** Specific priority subpopulations include individuals who are: homeless, suffer from serious and persistent mental illness (SPMI), dual eligible, newly eligible under Medi-Cal expansion, inmates in local jails (AB109 population), foster youth, youth in the juvenile justice system, and individuals falling into the top percentiles of total cost and/or utilization (e.g., hot-spotting). Some counties, such as Los Angeles County, were taking a geographic approach to targeting high-risk populations by trying to bring together multiple agencies in a coordinated "Health Neighborhood," in specific areas where concentrations of high-risk individuals were utilizing multiple county systems. It was notable that most county-level initiatives were relatively small in scale. For example, San Diego County's Project 25, Los Angeles County's Project 50 and Santa Clara County's Homeless 1000 all aimed to target 25, 50, and 1000 homeless individuals with robust case management and sometimes housing services, realizing that these small-scale efforts were only addressing a small fraction of the population in need. More importantly, despite multiple initiatives that required coordination across sectors in a given county, the sub-population-focused efforts were not coordinated with one another. Thus, while multiple discrete efforts in some counties represent a clear step towards whole-person care, there emerges an opportunity to make county-level systems more responsive to whole-person needs by unifying and drawing on best practices from individual efforts with discrete subpopulations.

> *"Why not start with a target population, do it well, and use as impetus to move beyond."*
> *– Mark Ghaly, MD, Deputy Director for Community Health & Integrated Programs, Los Angeles County Department of Health Services*

- **Stakeholders agreed that pairing whole-person care initiatives for the highest-cost sub-populations with broader population health efforts is a wise investment of public funds for both quality and cost outcomes.** Stakeholders acknowledged that there is a spectrum of need for whole-person care. Interviewees also recognized that county resources are not able to provide everything for everyone, and there will be an inevitable need to concentrate efforts on high-cost populations in order to show return on investment. However, stakeholders also expressed a strong sentiment that investing in whole-person care efforts that target at-risk populations before individuals become high cost is a desired strategy. Figure 2 depicts the notion that whole-person care could be considered for a broad range of vulnerable target populations. While interventions and models of care may vary in intensity depending on individual need, a whole-person care approach was viewed as beneficial to HUMS populations today and just as important for preventing high-risk groups from becoming HUMS in the future. Furthermore, some stakeholders saw a whole-person care approach as key to drawing attention to upstream social determinants of health as part of broader efforts to build and support healthy communities.

Figure 2. Whole-person Care Target Population and Care Model Continuum



- **A few counties have articulated a broader vision for population health that encapsulates the specific priority subpopulation efforts and efforts that extend to broader population health and wellness efforts (e.g. public safety, obesity prevention, healthy aging).** For example, San Diego County's Live Well efforts include initiatives that extend from high-risk case management programs for homeless individuals and their county's CCI implementation to local leaders encouraging and supporting active living and wellness at the community level.[29] Santa Clara County has endorsed a "Health for All" vision, suggesting that the target population for county efforts promoting health and wellbeing includes all communities. In fact, some stakeholders viewed whole-person care as a lever to advance a public health agenda for the broader population. Both San Diego County and Santa Clara County were able to leverage these population health visions in successful Community Transformation Grants from the Centers for Disease Control & Prevention. Finally, stakeholders in these counties shared that a population-health vision with a focus on health rather than illness can help engender strong political support for all health-related efforts in the county. It should be noted that despite these visions, our interviews did not reveal efforts that systematically and effectively linked individual clinical health and community-level population health efforts.

"Live Well San Diego provides the framework for many different things. If you frame things as wellness, [you'll be] successful in getting support from the Board of Supervisors and expanding to cover a range of initiatives.…'Winning on wellness' focuses on what we're trying to achieve for the whole population."

– Julie Howell, PhD, Senior Health Policy Analyst, San Diego Health & Human Services

"If you're talking about the whole person… morally and socially, we have to start reinvesting more dollars into prevention and the 0-5 population. Even though that's the harder place to get money to go, it's the best use of our money. We have a better chance at addressing community health before there's a problem rather than chasing after one 15 years later."

– Toni DeMarco, Clinical Services Manager, Behavioral Health & Recovery Services, San Mateo County

Patient-Centered Care

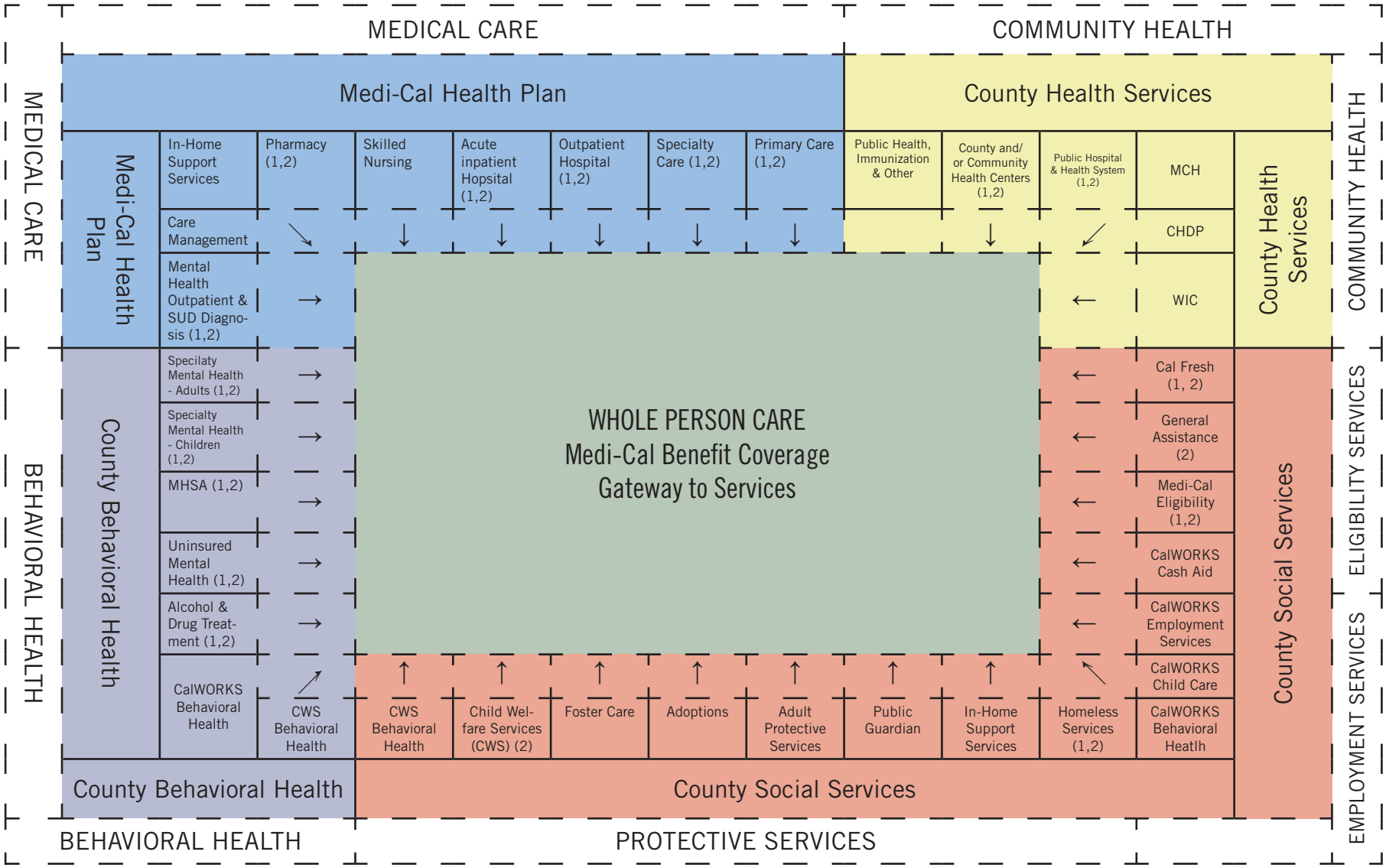
Patient-centered care can be generally described as providing the "right care, in the right place, at the right time." Interviewees across counties reflected that providers are committed to pursuing whole-person care and acknowledge that many Medi-Cal patients' social and behavioral health needs influence or even trump their medical concerns. Interviews across counties revealed the following:

- **Eligibility and enrollment in Medi-Cal represent the "essential gateway" for an individual to access whole-person care.** Medi-Cal eligibility is the literal access point for health services, mental health services for people with mild to moderate mental health issues, and substance abuse services. At the same time, because eligibility and enrollment into other services (CalWORKS, CalFresh) frequently occurs at the same time as the Medi-Cal eligibility determination, enrollment in Medi-Cal is often linked to other social services access.

  An assessment of programmatic interactions between Medi-Cal coverage and the broader array of county human services programs reinforces the centrality of Medi-Cal eligibility and enrollment for individuals receiving other services. Figure 3 shows most major publicly funded health and human services programs operated at the county level, either by counties or by Medi-Cal health plans. While the programs are organized under each local agency responsible for service delivery, the schematic reveals that Medi-Cal eligibility is a common, if not essential, gateway or through-put for most populations served by the publicly funded health and human services system. In other words, Medi-Cal eligibility is the primary entry point for individuals and families to access a variety of services, and determining eligibility is the key role played by each county Social Services/Human Services agency. In light of this dynamic, the social services agency in each county emerges as essential county partner in promoting a whole-person care orientation for the health and human services delivery system. First, it administers the Medi-Cal eligibility process. Second, it provides essential protective services, including child welfare and aging adult services, which also rely, in part, on Medi-Cal.

  It should be noted that for the residual uninsured, there is less of a single gateway to access whole-person care. While the uninsured will continue to seek and receive services from some of the county-level providers and agencies listed in Figure 3, stakeholders viewed the gap between need for whole-person care and not having the Medi-Cal "common denominator" as an issue that will require more consideration in any county whole-person care efforts. However, any cross-system coordination or care model change in the safety net that occurs at the local county level would likely benefit those who fall outside the immediate Medi-Cal-insured target population.This could include uninsured individuals or individuals who might be high risk but do not yet exhibit utilization across multiple systems, a common factor that some counties will likely use to identify a target population for early whole-person care initiatives.

Figure 3. Schematic of Whole-Person Care



Legend:
Medi-Cal Benefit Coverage
Medi-Cal Health Plan
County Health Services
County Social Services
County Behavioral Health
↓ Linkages to Medi-Cal
1 = released jail inmate/probation population
2 = homeless/housing insecure

About the Schematic: The schematic above presents the major health and human services (HHS) programs operated at the county level by county departments and the major components of health coverage administered by Medi-Cal managed care plans, which may be operated by counties. Each color designates a different responsible organization. The green center box shows that enrollment in Medi-Cal benefit coverage is a central component of -- a gateway for -- Whole Person Care. Medi-Cal enrollment either: 1) makes it possible for safety-net populations to obtain needed services, such as health care services, skilled nursing care, mental health services and substance use disorder services; 2) is a critical linking service that is essential to the delivery of other human services, such as foster care, In-Home Support Services, and CalWORKS; or 3) is a part of a larger set of services, such as income and food support (CalFresh), for low-income persons. The arrows indicate that there is a relationship between the program and Medi-Cal benefit coverage. As demonstrated above, nearly all HHS programs at the county level have a linkage with Medi-Cal, with the expception of public health services, which are "population-based."
The numbers (1,2) indicate where specific populations -- released jail inmates/probationers and homeless/housing insecure -- could be reasonably expected to access the larger HHS system. These multiple entry points show the range of departments and programs that may interact with these popuations and underscore the need for Whole Person Care.

- **Aligned eligibility standards for Medi-Cal and other social service programs was noted as an area for better patient-centered care and system efficiency.** Interviewees noted the state effort to embrace a "no wrong door" approach for Medi-Cal and social service eligibility and enrollment is a helpful step toward patient-centered care. However, this aspiration was viewed as compromised for patients and program administrators by the complexity of having similar yet different eligibility standards for Medi-Cal and state social service programs, such as CalWORKs and CalFresh.

- **There is currently no single care plan for individuals accessing services across multiple county programs, and there is usually no primary entity responsible for patients seeking care across systems.** Interviewees asserted that a "dedicated care coordinator" – both in the form of a lead responsible agency and an individual, culturally competent, linguistically appropriate coordinator – could improve patient-centered care, especially for patient populations that interact with multiple systems (e.g., a psychiatric emergency patient with medical and social issues was a commonly cited example). Some county interviewees saw a potential benefit of a uniform whole-person care assessment and assignment to a single accountable care coordinator as a method for providing the patient with a clear point of contact regarding their care across systems and creating clear responsibility among providers regarding who will oversee the coordination of an individual's services across systems. Interviewees also acknowledged that if a patient's needs change, the most appropriate care coordinator could change over time. Most interviewees also noted that wherever possible, the dedicated care coordinator should be at the provider level where the patient is most engaged in care.

- **Patient-centered health home (PCHH) transformation and behavioral health/primary care integration represent two key steps counties are taking toward whole-person care.** Providers pursuing PCHH activities reflected that a health home for Medi-Cal patients had to address both the medical and non-medical service needs of clients. PCHH activities such as implementing care teams, use of alternative providers, health information technology, and connecting patients with community-based services can all contribute to providing the "right care" and meeting whole-person needs. For most people, providing the "right care in the right place" means a primary care health home that coordinates whole-person care. At the same time, stakeholders acknowledged that for select clients, such as those with SMI and the chronically homeless, the most appropriate health home may be in a behavioral health or supportive housing setting with primary care integrated into that setting.

  One notable strategy that many counties have embraced to serve clients in the "right place" is integrating behavioral health services into a primary care setting so that the client can continue to go to the same health home, even as he or she may move along a continuum of behavioral health needs. For example, many counties had integrated mental health services into the FQHC setting and were serving individuals with mild, moderate and some severe mental illness within the primary care setting. Conversely, some FQHCs have also created

satellite sites within County Mental Health as key examples of reverse integration of primary care and behavioral health. A Mental Health Services Act (MHSA) innovations project in Los Angeles County also integrated medical and mental health providers on Mobile Health Teams to engage individuals with complex needs outside of any clinical setting. While the Los Angeles County project is one example, all counties noted that the MHSA of 2005 and associated funding were the genesis of their behavioral health and primary care integration efforts, demonstrating the catalytic power of state leadership and funding.

> *"[Whole-person care is]…a team approach to care delivery in which there's a common understanding of the care plan and goals that individual wants/needs to pursue. And that integrated care plan includes…health, behavioral health, but also includes social services, faith community – depending on the needs of individuals….it could include any or all of those agencies working together, with the clients in the center."*
> *– Robin Kay, PhD, Director, LA County Department of Mental Health*

Coordination of Care Across Sectors

Current county efforts around coordination of services across sectors are most frequently galvanized for specific priority populations. Table 3 shows numerous examples of smaller, targeted efforts in service coordination as a testament of incremental movement toward more coordinated systems. In discussing more expansive and systematic coordination of care across sectors, interviews revealed:

- **The most prominent care coordination activity across counties centered around four initiatives: behavioral health/primary care integration; coordination of aging, health, behavioral health, and in-home support services for dual-eligible individuals as part of CCI; supportive housing for chronically homeless; and services for the AB109 population.** Counties with Medicare Community-based Care Transitions Program (CCTP) grants were also pursuing activity around coordinating hospital transitions. Most efforts were focused on coordinating rather than integrating services, acknowledging that discrete providers often had areas of expertise that were worth preserving. For example, there was a perceived benefit to locating trained eligibility workers in jails rather than having jails train their staff to provide eligibility services upon releasing inmates. A notable exception where integration was held up as a goal rather than just coordination of services were efforts to integrate behavioral health and primary care services and an expressed desire to do so to a greater degree. Many counties were managing some portion of individuals requiring specialty mental health services within the FQHC setting. This was seen as a key strategy to avoid requiring the patient to switch providers when mental health status changed.

Table 3. County Examples of Coordination Across Sectors

Specific Sub-Population	Action	County Example(s)
Homeless	Intensive case management and connection to multiple services for homeless individuals; in some cases also includes housing	Housing 1000 in Santa Clara Project 25 in San Diego Project 50 in Los Angeles
SPMI population	Integration of county mental health and substance use services	• Dual-certification (double-boarded) program for physicians in family medicine and psychiatry (San Diego) • Sonoma & San Diego convening summits for primary care, mental health, and SUD providers • At the organizational level, Santa Clara merged mental health and SUD into a single behavioral health agency
Medi-Cal expansion population	Integration of Mental health and primary care	• Full Service Partnership in Los Angeles • MHSA-funded Innovations Program testing 4 models of integrated care that include MH, FQHCs, and SUD working together to develop shared care plans (Los Angeles) • BH providers in primary care/FQHCs working together to serve a common population (Santa Clara)
Care Transitions populations	Coordination between inpatient hospitals and receiving providers in the community (FQHCs or community mental health)	• Community-based Care Transitions Program (CCTP); Adult & Aging Services coordinates with long-term care supports program (Sonoma) • CCTP program using social workers to work with hospital and Aging Services staff for seniors (San Diego)
Dual eligibles	Housing with case management	The Health Plan of San Mateo issued an RFP for agencies to provide housing with integrated case management for select patients.
	Coordination between Aging services and other health players (coordinated by health plans)	San Diego San Mateo Santa Clara Los Angeles
Provider-led high-cost or high-utilizer groups	Nurse and LCSW case managers are intensively managing 50 highly complex patients	Partnership Health Plan-funded high-risk care management pilot (Sonoma)
AB109 population and incarcerated population	• Providing re-entry assistance to recently released prison population • Working with prisons to establish enrollment process	• San Mateo Service Connect program provides case management, health & mental health services, public assistance through effort of Human Services, Behavioral Health & Probation • Los Angeles social service case worker getting people enrolled in Medi-Cal
Juvenile justice	Coordination between behavioral health and juvenile justice systems	San Mateo community-based mental health team meets regularly with probation officers and providers (and departments are co-located)
Frequently arrested / SUD population	Coordination between sectors to identify population seen in jails and substance abuse treatment	Sonoma County Sheriff, local SUD provider (Drug Abuse Alternatives Center), and hospital looking at data and costs for specific population together
High risk mothers of young children	Public health and clinics sending nurses to do home visits	Multiple counties doing Nurse Family Partnership (e.g., Sonoma)
Foster children (up to age 21)	Coordination between child welfare and CalWORKS	• Santa Clara Linkages project entails joint case planning & joint intake • Santa Clara cross-agency service team (CAST) brings together agencies who serve children

- **Cal MediConnect represents the paramount example of coordination of care for one vulnerable population with potential to expand the model to other populations.** It is notable that many of the coordination of care conversations across sectors in Los Angeles, San Diego, Santa Clara and San Mateo Counties had been prompted by the duals demonstration project. Furthermore, many stakeholders saw the duals demonstration efforts to coordinate care across health, behavioral health, and social service sectors for dual eligibles as a precursor and model for similar efforts on behalf of other populations.

- **The new requirement in managed care Medi-Cal to provide services for people with mild to moderate mental health disorders is prompting MCOs and county mental health agencies to establish coordination of care strategies for those individuals who fluctuate between having moderate and severe mental health conditions.** For example, in multiple counties, the Integrated Behavioral Health Project is facilitating discussions and challenging MCOs and county mental health agency stakeholders to define coordination and communication strategies and to clearly delineate responsibility for care and funding of services for individuals who interact with both systems.[30]

> *"The system itself has a lot of barriers upfront for people unless you have some high-level, serious issues. Our systems aren't very good at assessing and then moving people to the right level of care. There's not consistency in how we all screen and that's a problem, statewide."*
> *-Anonymous Interviewee*

- **Many interviewees articulated that eventually having Medi-Cal MCOs become responsible for delivery of services for individuals with severe mental health conditions (in addition to mild to moderate) and substance use conditions could be a key facilitator for whole-person care.** Because patients tend to move along a continuum of behavioral health needs, a single responsible entity and single funding stream for Medi-Cal MCOs could facilitate more seamless patient care. Some interviewees noted that MCOs could leverage experience managing contracts with substance use disorder providers and severe mental health providers for commercial patients. Other interviews cautioned that such a change in financial responsibility should continue to honor the fact that county mental health providers frequently have the best expertise in caring for SMI patients.

- **There are important emerging examples of partnerships to address housing needs of vulnerable populations.** Housing instability and homelessness were identified as critical social issues that needed to be better addressed as part of whole-person care. Also, despite most services being tied to Medi-Cal eligibility, as outlined above, emerging partnerships between counties, housing assistance, and homeless services administered by public housing authorities, cities, and continuums of care are key examples of services that are important to addressing social determinants of health that are not administered by counties or connected to Medi-Cal eligibility. One notable example is Los Angeles County partnering with the Skid Row

Housing Trust (a housing developer) to build a 100-unit building where case management services are provided to extremely high-risk individuals. Another example is Santa Clara County's use of county dollars to support transitional housing for individuals receiving Medi-Cal reimbursed outpatient substance use disorder treatment. These examples point to the importance of extending cross-sector coordination efforts to include both county agencies and other public entities or community-based organizations.

- **Service delivery integration lags behind eligibility and enrollment integration.** Planning for health reform has stimulated much activity on integration of eligibility and enrollment systems (e.g., CalHEERS), and counties consistently reported that eligibility for social services (e.g., CalWORKS, CalFresh) frequently occurred at the same time and place as Medi-Cal eligibility determination. However, there has not been a comparable degree of integration on the service delivery side. For example, social service agencies did not know if clients sought services once they were determined eligible, and providers reported feeling frustrated by making referrals to social service programs or specialty mental health services and not having any systematic means of knowing that the patient received the recommended services.

- **Accountable Care Communities are emerging as a mechanism for coordinating services across sectors in two distinct ways in some counties.** The first way is through sub-county regional service areas that bring together all providers in a geographically defined region of the county to communicate about coordinated care for the safety-net populations they are serving in the same area. Examples include both San Mateo County's Community Service Areas for Medi-Cal populations and Los Angeles County's Health Neighborhoods for the seriously mentally ill. The second way is through nascent activities, such as those in San Diego County, to integrate public health, health, behavioral health, and social services under a single framework that emphasizes both prevention and wellness in addition to coordinated services for high-risk populations. Whole-person care was viewed as a helpful framework for approaching the idea of Accountable Care Communities, whether they were implementing a geographic or condition-focused approach to better caring for vulnerable populations or a broad-based population-focused effort because of the need to systematically coordinate across sectors.

Shared Data

A key tool for systematically coordinating care across sectors at the patient level and the system level is shared data. County agencies recognized the value of sharing data for the purposes of 1) identifying common client populations; 2) coordinating services for clients needing services in multiple systems; 3) identifying areas of opportunity for improvement and 4) performance measurement and evaluating success.

Key findings regarding sharing of data for multiple purposes included:

- **Counties saw value in identifying their HUMS patients, but most did not do so systematically, frequently citing restrictive legal interpretations of privacy laws.** However, many stakeholders commented that legal barriers to sharing data across systems, while real, are not as insurmountable as some perceive them to be.

- **Data infrastructure that allowed for health, behavioral health and other social services information exchange was seen as an important yet underdeveloped building block of whole-person care.** In fact, all counties we spoke to had different EHRs for mental health and health sectors, and many counties had multiple electronic systems within the health sector. Thus, data infrastructure that allows for interfacing between systems was viewed as a more realistic expectation than integrated data systems. While all counties reported having some systems that allowed for limited levels of interface and transfer of data, San Diego County notably articulated a vision for building a system that would allow interface between data in the health information exchange, county information systems, and a community-based services information exchange. San Diego County also noted that rather than trying to struggle for a single patient identifier, they were implementing programming algorithms to match patient records across systems. Interviewees noted that creating data interfaces for the purpose of care management required overcoming both real and perceived legal constraints to data sharing. Use of universal consents and opting out rather than opting in to having data shared were both cited as strategies for overcoming data-sharing barriers.

- **Stakeholders cited that it would be helpful to have intra-agency communication regarding one another's goals, and consensus on a few shared performance metrics.** For example, many county social services agencies use the authorized standard of 45 days as the timeframe for eligibility determination; yet, for the health sector, a delay in meeting a patient's immediate need for behavioral health, substance use, and health services can result in avoidable hospital utilization. Potentially shared goals between health and social services on expedited processing time for select cases could result in improved access to care, quality outcomes and lower county costs.

> *"…a mechanism to share the data – if you have someone who is well-cared for by multiple case managers, they don't have a common platform to share info and there's a lot of redundancy between them – and all would have access to it."*
> *– Robert Moore, MD, MPH, CMO, Partnership HealthPlan*

Financial Flexibility

The notion of financial flexibility was consistently acknowledged as a key facilitator of whole-person care, and siloed funding streams were frequently cited as a barrier. A review of the multiplicity of funding sources underscores both the fragmented nature of financing for health, behavioral health and social services and the complexity of this funding in California counties. Among the county agencies shown in Figure 3 above, all are funded by multiple funding streams with different rules and regulations for eligibility, service provision and payment. While the complexity of these funding streams makes a single graphical display of multiple streams difficult to present, interviewees uniformly commented that siloed funding streams create and perpetuate disincentives for coordination, often resulting in agencies providing siloed, disconnected services. Furthermore, there was nearly universal agreement among interviewees about the critical importance of obtaining financial flexibility through innovation and policy changes if health care entities are to meet Triple Aim goals of improved health outcomes, and counties are to achieve efficient use of public resources across sectors.

While all counties noted that siloed funding streams for mental health, substance use, and health are a barrier to whole-person care, interviewees' opinions differed on the relative advantages and disadvantages of integrating financing via braiding funding (leaving categorical streams intact) versus blending funding (pulling all funding streams together).[d] Interviewees also consistently acknowledged that state and county leadership greatly influences whether braided or blended funding strategies are implemented. Table 4 details numerous examples of blended and braided funding strategies that counties described to meet whole-person needs and provide coordinated care to discrete priority populations. Key findings on the topic of financial flexibility included:

Barriers within Managed Care Medi-Cal

- **MCOs are able to use the flexibility of their managed care capitation rate (a form of blended funding) to meet whole-person needs, but have not done so systematically for a variety of other reasons.** First, while the state has told plans they can use their capitation rates flexibly, MCOs reported mixed signals regarding the flexibility they actually have to invest in whole-person services. In particular, while the state has told plans that they can use their capitation rates flexibly, only covered medical services count when looking at historical costs to set future rates. Thus, MCO investments in services that are not strictly medical, but which improve patient health and lower costs, may simply lead to rate cuts in the future. Second, interviewees cited California's 50th in the nation Medi-Cal spend per capita[31,32] as a barrier to financing the coordination of services; capitation rates that often require plans to pay provides extremely low rates compared to Medicare or private insurance for the medical services rendered were also historically not viewed as having "extra dollars" that could be spent

d Blended funding, such as that being used in state duals demonstrations, refers to when two agencies at any level (e.g., county, state, federal) agree to jointly fund a set of services, and the funds are pooled into a single payment to organizations responsible for delivering or contracting for the delivery of services. Braided funding refers to two or more agencies jointly paying for a package of services but the funding stream and reporting requirements remain separate.

experimentally on non-medical coordination services.[33] Third, interviewees also articulated that managed care Medi-Cal plans generally had a cultural norm of utilization management rather than care coordination. Fourth, in California's county-based Medi-Cal managed care system, there is significant variation in health plan practice across counties and across plans. Finally, both providers and plans suggested that limitations in Medi-Cal funding for certain types of providers that might provide coordination services (e.g. community health workers, marriage and family therapists, and bachelors-level case managers all came up in interviews) prevented such services from being funded.

The results of these articulated barriers is that MCOs have not systematically transferred the financial flexibility to coordinate services to providers, and MCOs have not historically tended to use the flexibility of their capitation rate to fund cross-sector care coordination. Indeed, interviewees reported that California Medi-Cal MCOs have mostly focused care management and coordination services narrowly on nurse case management of medical services, rather than coordinating services to address the underlying behavioral health and socioeconomic needs that influence health outcomes and utilization.

- **Many providers noted both a need for cross-sector care coordination and a lack of systematic means of paying for such care coordination across sectors at the provider level.** Resources solely dedicated to care coordination activities across sectors are not clearly designated, resulting in a lack of systematic means of paying for care coordination at the provider level. Many interviewees also commented that while MCOs do some care coordination, patients respond better and care coordination is more integrated with other medical services and care plans if care coordination originates from the provider rather than the health plan. Interviewees also discussed both duplication of some case management services for select patients that interact with multiple systems and a general underfunding of care coordination across sectors.

Strategies for Flexible Funding for Whole-Person Care

- **Innovative use of financial incentives has spurred significant changes in care delivery and outcomes in some counties.** For example, San Diego County's LIHP program used sizeable pay-for-performance incentives to spur network expansion, PCMH transformation, behavioral health/primary care integration, and quality improvement in the safety-net, resulting in significant reported improvements in health outcomes and delivery system transformation. In a Sonoma County example, a Partnership HealthPlan investment in high-cost case management at the provider level has shown marked reductions in inpatient utilization.

- **The blended funding in duals demonstration projects has stimulated novel discussions between sectors,** innovation in coordination of services, and more flexible use of funds to support health and prevent hospitalization in San Mateo, Santa Clara, San Diego and Los Angeles Counties.

A notable example is the Health Plan of San Mateo (HPSM) issuing a single RFP for case management and supportive housing. HPSM reported this innovative use of MCO capitation dollars for housing was deemed legal but that the plan should not expect that the expenditure on housing would be counted in actuarial rate setting of future health plan rates. In another example in San Diego County, health plans were engaging the Area Agency on Aging (AAA) in further braiding the blended funding of the duals demonstration with other existing programs funded by the Older Americans Act (e.g., case management, limited services, and integrated call centers) to optimize outcomes for consumers. The AAA, which administrates integrated in-home services and supports (IHSS), adult protective services (APS), a care transitions program, veterans services, and serves as public administrator, public guardian, and public conservator, was also engaging in novel contracting with the MCOs to provide in-home support services for Cal MediConnect members.

- **The Medi-Cal expansion has generated discussions among MCO and provider stakeholders about how to best use new federal dollars for the Medi-Cal expansion to meet the multiple needs of this newly insured population.** Medi-Cal MCOs now have federally-supported funding for the Medi-Cal expansion population and the dual eligible population, as well as the obligation to spend the funds (to keep an 85% medical loss ratio). Counties expressed eagerness to take advantage of the new stable source of coverage and payment to provide better care coordination across more than just the health services system, especially since the newly covered population and the dual eligible population may also be accessing many other services in the county.

- **Medi-Cal expansion could allow counties to spend county dollars with more flexibility.** Despite the 2013 Health Realignment,[e] some counties acknowledged that the Medi-Cal expansion may free up some county-level dollars to finance care for residual uninsured populations or to spend county dollars flexibly on other services within county systems, such as case management and housing initiatives for particularly vulnerable patients with housing instability.

- **Various interviewees viewed aligning the financing for Medi-Cal health, severe mental health, and substance use disorder services as a key facilitator of whole-person care in the future.** While some interviewees saw blending financing for health and behavioral health as the key strategy for facilitating whole-person care, others did not agree that blending funding was the best answer. Some interviewees also cautioned that categorical funding currently exists for good reasons[f] and that such a change would require very carefully planned implementation.

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e In 2013, California required a portion of the funds that previously supported county-based care to indigent individuals to be redirected to the state in recognition of the new availability of federal funds to support health coverage for many of the same patients.

f The following California Health Care Foundation paper offers explanation of how and why counties receive separate funding for mental health and substance use today: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/T/PDF%20TheCrucialRoleOfCountiesInCA.pdf

Table 4. County Examples of Braided and Blended Funding

Specific Sub-Population	Action	County Example
Homeless	Using Section 8 housing vouchers for housing and Medi-Cal for case management	Los Angeles (Health for Homeless)
FQHC patients and some SPMI who can be managed in primary care	County mental health dollars are used to pay for behavioral health staff in FQHCs	San Diego San Mateo Santa Clara Sonoma
	FQHC satellite clinics in Mental Health Clinics for SPMI patients	Sonoma
Specialty Mental Health patients (with significant comorbidities)	Using MHSA Innovations funding to pay for special programs that involved team meetings for staff, extensive outreach/engagement, and housing	Los Angeles
SUD Population	Using County funds for transitional housing for unstable/homeless patients while individual in outpatient treatment for SUD	Santa Clara
	• MHSA funds were used to fund a psychiatrist in substance use inpatient rehab program • HUD funding to provide intensive residential treatment for homeless SUD patients	Sonoma
Dual-eligibles	Cal MediConnect is blending Medicare and Medicaid funding in MCOs	All CCI Counties (including LA, San Mateo, Santa Clara, San Diego)
Seniors	CMS grant funding for care transitions and Aging services (under Dept. of Public Health in Sonoma)	San Diego Sonoma
Mothers with young children	Using case management dollars (1/3) plus local realignment funds (2/3) to pay for home visits for maternal child health population	Sonoma

Opportunities for Whole-Person Care in California

While opportunities emerged from our interviews across all dimensions of the whole-person framework, this section groups specific opportunities by the lead entity that might pursue next steps: county-level collaboration, statewide groups/foundation support, and state policy reforms.

County-level Collaboration

Counties are pursuing substantial activities to move towards coordinated care within individual sectors; however, county agencies and other local safety-net stakeholders identified by the county have an opportunity to develop a unifying strategic vision to do whole-person care at the local level by envisioning, planning, and coordinating efforts across sectors. Active and committed collaboration among county agencies and other stakeholders – including but not limited to public health care systems, non-profit FQHCs, mental health and substance abuse providers, social services, housing authorities and community organizations, criminal justice, and Medi-Cal managed care plans – emerges as the foundational component for developing a whole-person care strategy to serve vulnerable and at-risk populations. By looking beyond categorical program barriers and developing a united approach for delivering health and human services, whole-person care can take shape. The following next steps emerged as potential county-level opportunities:

- **Convene collaborative leadership.** Convening leaders of key county agencies and other key local stakeholders to define a whole-person care vision can create a platform for staff (service providers, financial, data, IT) to collaborate in new and different ways and to identify opportunities for multi-sector collaboration. Initial cross-sector tasks could include:
    - Reviewing how other counties are approaching whole-person care efforts and challenges, including addressing legal/privacy concerns to overcome data sharing barriers and best practices for coordinating services for specific target populations.

- Setting shared goals, with an emphasis on aligning social service and health sector goals regarding eligibility, enrollment and referral to services. For example, agencies might set goals for percent of patients being enrolled in Medi-Cal are also being enrolled in other programs for which they are eligible.

➤ **Implement a coordinated whole-person care model.** A whole-person care model would likely include the following characteristics and could include others defined and agreed upon by stakeholders in individual counties:

- Each client/patient has an individualized care plan based upon a standardized assessment of his or her medical, behavioral health, and key social needs, such as shelter. This care plan would be shared across agencies.
- Each client/patient is assigned a single, cross-sector "dedicated care coordinator" based in the agency that is most appropriate for that individual's needs. This person may be a behavioral health provider located in supportive housing for the chronically homeless, or a nurse case manager at a primary care site. Establishing consistency and trust with one care coordinator is critical. This care coordinator also serves as the point of contact for all agencies providing services to the individual client/patient.

"…People are hungry for the model. The health home is really the standard now. How do we brand the model and have the policies and leadership to push it?"
- Rita Scardaci, RN, MPH, Director, Sonoma County Department of Health Services

➤ **Share data.** County agency leaders and other key stakeholders identified by the county, such as FQHCs and/or Medi-Cal MCOs, will likely begin by identifying a shared target population of individuals who are high-risk and high-cost in multiple systems. If each agency identifies their top 100-500 highest-risk clients and agencies analyze the overlap, all pilot efforts of this sort suggest that the agencies will share many of the same highest-risk clients. Some counties that have already done this task may choose to look at a broader population.

A second step in data sharing is to develop real-time processes to share appropriate information among providers across agencies for coordinated, individualized care.

A third important step in data sharing is to define common outcome and efficiency metrics that can evaluate progress for the defined target population. Even if analyzing outcomes across systems is not immediately feasible, a step to advance whole-person care could include having each agency track their current metrics for the shared population and share the metrics across participating agencies.

"What I've found is that what people feel are restrictions on data sharing are more perceived than real."

- Anonymous Interviewee

Data sharing efforts will require addressing the current obstacles to this seemingly straightforward task, including addressing privacy concerns, legal concerns, different patient/client identifiers and non-compatible IT systems. It is important to note that numerous counties have successfully overcome these barriers with collaborative leadership and political will through such strategies as adopting a universal consent form and/or implementing an opt-in/opt-out approach to data sharing. Others have recently explored the question of perceived versus real barriers to data sharing.[34]

Finally, it is critical to note that all flexible financing strategies must be supported by robust data.

- **Adopt a flexible financing strategy.** A first step in adopting a flexible financing strategy at the county level could begin with agency financial directors coming together to evaluate funding strategies and alternative payment arrangements to fee-for-service (FFS) that could support whole-person care, while taking advantage of federal funding opportunities. Such flexible funding strategies that could be considered include:

  - Blended funding: At the county level, plans could use blended funding arrangements in their payments to providers. Examples of blended funding could include global capitation for all primary care or professional services or supplemental per-member-per-month care management or care coordination payments, sometimes called partial capitation payments, which providers could use flexibly for care coordination and case management, in addition to health services. It should be noted that providers that take on higher levels of financial risk through capitated arrangements must have adequate data and risk-management capabilities to make such arrangements meaningful and sustainable.[35]

  > *"A lot of it comes down to funding flexibility. Where you have capitated systems of care – where money can be used flexibly, [you have] greater opportunities to knit together organizations – money follows the patients. Whenever you have money going to organizations, other priorities outweigh patients… It's really hard to make it [whole-person care] happen at the provider level unless you have this [funding flexibility]."*
  > *– Anonymous Interviewee*

  - Braiding county funding and state/federal/private funding: Braiding funding strategies can be used combine categorical health funding streams with other funding streams to support unmet patient needs such as housing, food insecurity, unemployment, or integrated behavioral health services.

- Maximizing federal funding: One obvious county-level maximization strategy is ensuring that all people eligible for Medi-Cal are enrolled and are receiving the full scope of Medi-Cal benefits, so that county funds can be freed up for the remaining uninsured or non-covered Medi-Cal services. A potential second strategy consists of hospitals and county eligibility departments working together on strategies to ensure that people who are provided temporary Presumptive Eligibility (PE) benefits actually complete a Medi-Cal application and are assessed for full eligibility, especially for some of the County's highest-risk populations who are just becoming eligible for Medi-Cal.

> *"The [blended] funding streams help a great deal because you're not having one sector saving money for another sector."*
>
> *– Robert Moore, MD, MPH, CMO, Partnership HealthPlan*

- Payment reforms that move away from FFS: In addition to capitation arrangements, payment reforms that move away from FFS toward payment for value could include shared-savings arrangements between plans, providers, and county departments that provide financial incentives for implementing whole-person care processes and achieving desired whole-person care outcomes. Outcomes could include traditional health services Triple Aim measures such as decreases in avoidable hospital admissions, readmissions and emergency care, health quality measures and patient experience, but might also eventually extend to decreased recidivism, decreased arrests for substance-use-related events, or decreases in processing time for Medi-Cal eligibility.

Statewide Groups/Foundation Support

Interviewees identified two types of support that statewide groups and associations, and foundations, could provide to facilitate to advance whole-person care. These opportunities broadly fell into two categories: opportunities at the individual county level and opportunities for cross-county collaboration.

Technical Assistance and Facilitation of County Agencies and Local Stakeholders

- **Convene Collaborative Leadership.** Within individual counties, there emerged an opportunity to provide technical assistance and facilitation to collaborations of agencies and other local stakeholders. Examples included:

  - Facilitate convenings to catalyze and support inter-agency collaborations and collaborations with community-based health and behavioral health providers at the local/county level. Sometimes an outside impetus can stimulate discussion among siloed entities. Offering counties a facilitated discussion among county agencies

using the whole-person care framework could accelerate the coordination. For example, the group interviews we conducted in individual counties has spawned subsequent inter-agency discussions and stimulated interest in the whole-person care approach. It should be noted that such convenings of cross-sector stakeholders in individual counties could serve as a key step in readying counties to implement Accountable Communities for Health under the California State Innovation Model.

- **Support Adoption of Whole-Person Coordinated Care Models**
  - Facilitated conversations could help county agencies develop specific care coordination best practices (e.g., agreeing on which entity is the responsible agency and who the "point-person" care coordinator is for individual patients) and to develop protocols to implement these best practices across sectors.

  - Some counties may choose to endorse a whole-person care model that accounts for social determinants of health and endorses prevention as part of emerging efforts to build Accountable Communities for Health at the county or sub-county level.

- **Facilitate Date Sharing**
  - Grant funding could provide support for a data analysis of individuals using multiple systems.

  - Through convening county councils and providing examples of MOUs, state associations could facilitate discussion on how to address privacy concerns and legal obstacles to data sharing and build consensus or clarification around when and how data could be shared. By supporting dialogue on actual versus perceived legal constraints to data sharing across sectors, counties could work through the varying perceptions and interpretation of legal limitations to data sharing for the purpose of patient identification, care planning, and care delivery.

- **Promote Flexible Financing Strategies**
  - State associations could work with policymakers to explore and adopt the state policy recommendations discussed below.

"With whole person care, I know the focus has been on the top 5-10% of complex populations – but I think we need to look at the large population and incorporate more resources, training, [and a] series of supports for the patients we're seeing to address social determinants of health. Things from financial literacy to CalFresh, emerging literacy programs, aspects like poor housing - those [impacting] a broader population are a very important focus for whole person care. We need both."
– Mary Maddux-Gonzalez, MD, CMO, Redwood Community Health

- Grant support could support county education and exploration of flexible financing strategies discussed above.

Facilitation of Statewide Collaboration of Health, Behavioral Health and Social Service County Leaders and Their Associations

- **The associations that represent county agency leaders can model the foundational collaborative leadership needed at the county level, and give aligned support to their members in counties initiating whole-person care.** In particular, statewide associations could establish a statewide peer community of county staff leading whole-person care efforts to share effective practices on specific issues that all counties are struggling to address. Examples of actions that cross-sector leaders from multiple counties might address together in a statewide peer community include:
  - Creating and validating a standardized whole-person screening tool to be used across agencies for assessing social determinants of health[g]
  - Developing common metrics and reporting processes for whole-person care
  - Highlighting effective use of flexible financing strategies that address common challenges such as provision of supportive housing, care coordination across sectors, aging services and health services integration for dual eligible beneficiaries, and behavioral health/primary care integration
  - Bringing finance directors from county agencies and associations together to identify how various waiver and non-waiver financing strategies would be financially supported and implemented at the local level

State Policy Reforms

Pursuing financing policies that support whole-person care and increase financial flexibility to address psychosocial client needs and the need for care coordination across systems arose in every interview we conducted. Across county interviews, three common areas emerged for state policymakers and stakeholders to consider in the advancement of whole-person care in California: opportunities for state-level action without federal engagement, DHCS initiatives to promote whole-person care, and opportunities for DHCS engagement with the federal government in innovative efforts to meet the Triple Aim in Medicaid.

State-Level Action without Federal Engagement

CMS has outlined opportunities for states to implement key delivery system reforms in Medicaid without needing to change state plan amendments or request waivers.[h] [36] Similarly, stakeholders identified three major ways for the State to pursue reforms that could allow or promote using existing

g A side benefit of a standardized assessment conducted across counties and across agencies would give county leaders the data to more systematically quantify unmet needs of community-based services (e.g., affordable housing stock).

h In 2013, In 2013, CMS published a memo on various federal mechanisms available to support care coordination for high utilizers: "Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality." CMCS Information Bulletin, July 24, 2013. Available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-24-2013.pdf.

funding streams more flexibly to provide whole-person care without needing to involve CMS:

- **Promote financial flexibility strategies within Medi-Cal managed care.** Encourage MCOs to delegate care coordination to provider groups where possible, to create flexible funding mechanisms for non-medical services and expenses, and to set up payment systems that allow providers to share in the savings from reductions in total costs. The state could promote and encourage promising models of plan-provider payment reform, such as shared savings and care coordination incentive payments that give providers financial support to deliver enhanced care coordination and case management. For example, recognizing the deep role that social determinants play in health and drawing on Oregon's Coordinated Care Organization example, county providers might advocate for small flexible funding accounts that providers could use to cover relatively inexpensive non-medical expenses that could impact health outcomes and utilization.

- **Explore other financial flexibility strategies in Drug Medi-Cal, State-only Medi-Cal or county funding.** Financial flexibility could include exploring opportunities for counties and MCOs to use State-only Medi-Cal to cover the services that support housing stability for homeless people with complex health and social needs because a waiver is not needed to use state-only or county dollars to pay for housing that could help reduce avoidable hospitalizations. Because gaining approval to use Medicaid funds for housing can be a contentious issue, MCOs might start by seeking approval to use Medicaid to pay for some of the non-housing costs of supportive housing, particularly the flexible services that promote whole-person care and housing stability.

  Another key opportunity is for the state to support the integration of treatment and recovery support services for co-occurring mental health and substance use disorders in non-treatment-facility settings. For example, Drug Medi-Cal could provide reimbursement for interdisciplinary integrated teams providing treatment to individuals with substance use disorders in a range of patient-centered settings, including mobile street outreach, home visits, and primary care, instead of only in a facility certified as a substance use treatment facility.

> *"There's a legal timeline attached to Medi-Cal processing and we may not see the same urgency as the health systems does (e.g. if they show up for a service at the hospital and need to be enrolled immediately). While we may meet the legal requirement, it may not meet the patient requirement."*
> *-Anonymous Interviewee*

- **Align eligibility standards in State programs and expedite eligibility for high-risk groups.** Because Medi-Cal eligibility is now "the essential gateway" to receiving health, mental health and substance use services, as well as getting enrolled in other programs within social services when Medi-Cal eligibility is being determined, interviewees suggested the following opportunities for State policymakers to consider:

- Promote and facilitate expedited eligibility processes for high-risk populations, including strategies such as allowing presumptive eligibility in select outpatient settings.
- Explore opportunities for use of the same eligibility standards across all groups to ease eligibility processing and thus improve access to Medi-Cal and other state social service programs. Interviewees noted that social service entitlement programs rely on different eligibility standards, including MAGI for those associated with expanded health coverage under Medi-Cal and Covered California, and different standards for SSI, CalWORKs and SNAP (CalFresh).

➤ **Support and promote data sharing.** Given the paramount importance yet underdeveloped state of data sharing, the state could encourage MCOs to share data with providers, create legislation or clarification regarding sharing data across multiple systems, and support data sharing through using State Innovation Model resources to establish data sharing processes, analysis approaches, and data infrastructure.

DHCS Initiatives to Promote Whole-Person Care

There were numerous opportunities identified for DHCS to lead initiatives that would require some level of federal approval. Such examples included:

➤ **Collaborate with the federal government to pursue federal approval for changes to Medi-Cal to increase funding flexibility.** Vehicles for change could include federal 1115 waivers, other waivers, and state plan amendments. Specifically, interviewees across counties identified the following opportunities:

- Blend Medi-Cal funding for severe mental health, substance use disorders and health. Many cited the advance of pharmaceutical advancements for treating substance use disorder as one of many factors that supported this recommendation.
- Blend Medi-Cal funding for mental health and substance use disorders to allow more flexible use of case management services for those with substance use disorders.
- Pursue a permanent coordinated care Health Home Medicaid benefit (via a State Plan Amendment), and leverage Section 2703 of the ACA, which provides for enhanced reimbursement at 90% federal matching funds for two years. Funds could support cross-sector care coordination and data sharing for vulnerable Medi-Cal populations with chronic conditions and severe and persistent mental illness, recognizing that these two populations may have differing health home needs and costs of care coordination.
- Implement FQHC payment reform pilots to translate FQHC revenue into a per-member-per-month equivalent that could be used more flexibly.

DHCS Engagement with the Federal Government in Innovations in Medicaid

As a large and influential state, California has the opportunity to join with other vanguard states to accelerate innovation in the Medicaid program. Ideas emerging from interviews to this end included:

- **Seek federal approval to use Medicaid funding for supportive housing for select high-risk populations.** While New York encountered challenges in proposing to use Medicaid dollars for housing under their recent waiver, California, New York, and other states could collaborate to advance the argument to CMS that if paying for housing reduces the cost of healthcare while improving outcomes, then such a federal strategy should be implemented to meet the Triple Aim in Medicaid.[37]

- **Influence CMS to work with other federal agencies to identify federal-state opportunities to promote more integrated, coordinated care across sectors, with an emphasis on housing.** For example, given the cross-county issue of lack of housing being a barrier to achieving the Triple Aim in the safety-net population, the state could advocate at the federal level for CMS and the U.S. Department for Housing and Urban Development (HUD) to pilot an integrated housing for health financing stream.

- **Advocate at the federal level for CMS and other agencies to create a sustainable funding stream for Accountable Communities for Health (ACHs).** Accountable Communities for Health are gaining increasing interest nationally and are an articulated workstream in California's State Innovation Model. While SIM funds may support two or three Accountable Communities for Health in the near term and wellness trusts have been posited as a mechanism for aggregating funding, there is no clear standardized sustainable funding stream to support the cross-sector coordination and prevention-related activities that benefit all payers and sectors in an ACH. If California's ACH pilots prove successful, California should leverage such success to solidify federal investment in long-term population health at the community level.

Conclusion

2014 represents a time of historic change in the health sector. Major policy shifts enabled by the Affordable Care Act are expanding coverage to previously uninsured populations and promoting delivery system and payment reform. This time of change with increased demands for accountability has clearly led health sector leaders at the state and county levels in California to the conclusion that achieving the Triple Aim for the Medi-Cal population will require increased levels of collaboration between the health, behavioral health, and social services sectors. Facilitated by new financing strategies, such new care models characterized by increased coordination across sectors is essential to address the complex array of health, behavioral health and socioeconomic issues that ultimately impact patient experiences, utilization patterns, and health outcomes. Such new levels of collaboration hold promise to result in achievement of the Triple Aim and could have positive impact that extends beyond the health sector into other publicly supported sectors, such as behavioral health and social services, and potentially public safety and criminal justice.

The findings and recommendations in this paper represent the culmination of both a national scan of whole-person care models in the public sector and interviews with thought leaders and stakeholders from health and public health, behavioral health, managed care Medi-Cal, and social services. Conducted in five California counties representing 43% of the California population, this work represents a sample of the "on the ground thinking" at the California county level. The overarching recommendations for county and state stakeholders can be summarized as:

Adopt Whole-Person Care as a unifying framework to meet the Triple Aim and reduce health disparities in Medi-Cal while also reducing costs and improving outcomes in other publicly financed programs. The whole-person care framework can be a useful for counties and the state because it can serve as a unifying vision for payment and delivery system reforms that acknowledge the significant influence of social determinants of health. The framework can help create a galvanizing platform because the concept resonates with diverse stakeholders and provides a systematic approach to coordinating health, behavioral health, and social services for vulnerable populations.

Convene stakeholders from health, behavioral health and social service sectors at the county and state levels to implement whole-person care models. Developing whole-person care models will require collaborative leadership and data sharing in order to promote and support service coordination across sectors and patient-centered approaches to care. The report outlines specific opportunities that local health providers and counties can pursue to develop whole-person care models. In some counties, this may take form of focusing on a target population of the highest-risk individuals interacting with multiple county systems. In some counties, whole-person care may blend efforts to establish Accountable Communities for Health at the county or sub-county level in a way that recognizes social determinants of health with efforts that focus on care coordination and prevention.

Pursue payment reforms at multiple levels to allow flexible use of funding and aligned incentives that will facilitate and support whole-person care models and strategies. Flexible funding at the state level through waivers and related ACA provisions should be complimented by payment reforms at the county and provider levels that increase flexibility for delivering care to individuals in patient-centered ways that invest in novel cross-sector care coordination. State policymakers and managed care Medi-Cal plans and counties will need to explore braided and blended funding strategies as well as payment reforms that promote achieving the Triple Aim as critical facilitators to realizing a whole-person care model.

It is important to note that many of the identified opportunities align significantly with other state-led efforts such as the SIM grant and DHCS concepts for the next California 1115 waiver, while also offering concrete next steps and ideas for county-level leaders, state-level foundation and association leaders and state policymakers. Our hope is that the whole-person framework, findings and opportunities can both guide and support California leaders as they explore new approaches to caring for the state's vulnerable populations.

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Table 1. Dimensions of Whole-Person Care

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Appendix A.
County Examples of Coordination Across Sectors

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Dimension of Whole-Person Care	Los Angeles	San Diego	San Mateo	Santa Clara	Sonoma
Collaborative Leadership	• Housing for Health led by DHS (Mitchell Katz & Mark Trotz) with support from Board of Supervisors • High amount of collaboration but depts. are understaffed and overwhelmed (with ACA) • County CEO Office brought in Service Integration Branch to facilitate collaboration with limited success in fostering collaboration between agencies	• Strong collaborations between health plans ("speak as one voice") and, to some extent, hospitals • Council of Community Clinics has facilitated many of the integration efforts with behavioral health • Healthy San Diego (managed care) • CAO and Board of Supervisors have championed the Live Well strategy/mission • County provided funding to Council of Community Clinics to facilitate integration activities (learning communities, summits)	• Political will to support initiatives with County dollars • Highly collaborative: small group of senior people meet regularly (health plan, hospital, behavioral health) • County has strong relationship with Health Plan of San Mateo	• Personal relationships between some people in certain agencies that has served as a facilitator to coordination (e.g., Bruce Copley and Rene Santiago) • Health Care Reform Task Force/Stakeholder Group [funded by the county] • Example from Homeless 1000: homeless population was prioritized as a target population	Health Action Plan – 2020 Vision for Sonoma County that includes community health goals • Funded by three large hospitals in the county • Convened by Board of Supervisors, spearheaded by Health Officer in Public Health Department CMMI grant • Hospitals have promoted community health through their leadership and message that health is outside of the four walls of the hospital • Redwood Community Health Coalition has played an active role in the community, has brought the healthcare community together
Target Population	Focusing on high-risk subpopulations: • Homeless population prioritized by DHS (~50,000 homeless in LA County) » Housing for Health – housing for high-cost and homeless patients in hospitals » Project 50 - goal to house 50 of county's chronically homeless • AB109 population • SMI population • Medi-Cal expansion population	• Target population includes the entire county through Live Well San Diego • Focusing on high-risk subpopulations: » Dual eligibles » Behavioral health » LIHP - early expansion population » Homeless (e.g. Project 25- housed high-cost patients that were homeless) • Data-sharing efforts in Health & Human Services focused on adult multi-service users	• Focus on broad community to reach safety-net populations • Specific high risk sub-populations within safety net (with special focus on duals and seniors, given San Mateo is an older county): » AB109 and parole » County conservatorship » Homeless » Dual eligible and seniors » "System of care" kids » SPDs » Juvenile justice	Focusing on high-risk subpopulations: • Homeless (e.g. Homeless 1000 project) • AB109 population • Meth-using mothers with children • EMS high utilizers • Transitional housing program for DADs population • "System of care" kids • Child welfare Emerging vision of joining efforts, but it is not fully articulated and shared across sectors/agencies.	Focusing on high-risk subpopulations: • Aging population • Dual eligibles • High-cost Medi-Cal patients • Homeless mental health patients • SMI population • Substance abuse population interacting with corrections system (arrested or incarcerated) • High-risk, low-income mothers with young children

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Dimension of Whole-Person Care	Los Angeles	San Diego	San Mateo	Santa Clara	Sonoma
Patient-Centered Care	• Behavioral Health integration for SMI population: co-location of behavioral health specialists in some primary care clinics and Full Service Partnerships	• Behavioral Health is an integrated department of mental health and substance use » Every community clinic has a behavioral health provider and mental health clinics all have relationships with FQHCs » Integration extending to those with SMI » Used LIHP to push integration of BH further through P4P incentive » Family Resource Centers - ensure people access social services benefits	• Aiming for integration of Behavioral Health and primary care	• Patient-Centered Medical Homes	• High-cost case management program run out of health centers
Coordination of Services Across Sectors	• Developing "health neighborhood" concept: Dept. of Health Services, Public Health, LA Care, and the community clinic association working on this together (seeking grant funding) • Eligibility and enrollment (Dept. of Public Social Services (DPSS)) » Co-location of general relief enrollment in mental health clinics » Developing eligibility system that will encompass CalWORKs, general relief, & MediCal » Coordination of case workers within different parts of DPSS • MHSA-funded Innovations Program: testing four models of integrated care that include mental health, primary care (FQHCs), and substance abuse working together to develop shared care plans • Housing initiative has brought together multiple sectors » Project 50 - involved 17 different agencies (with a universal consent form) • Service Integration Task Force created, but has had limited success	• Population health efforts (most are part of Live Well San Diego) » Community Transformation Grant (CTG) and CPPW grant » Health Homes: supported through the LIHP program • Homeless initiative - Behavioral Health working with social services providers to provide access to benefits • Duals demonstration program promotes collaboration between health plans and county aging services and AOA-funded services • Care Transitions (CCTP grant): social workers work closely with hospital and AIS staff ensure needs for supportive services are met at home • Some clinics working with social service providers (WIC, childcare) but is specific to clinic connections • 2-1-1 San Diego provides linkages/referrals to many public programs, and is being certified to become MediCal navigator	• Community Service Areas (CSAs): comprehensive planning process to create 6 CSAs and build capacity in geographic communities to tap into available county resources and meet community-specific needs • Eligibility: coordination of processes for Medi-Cal, CalWORKS, CalFresh, and SSI through Human Services Multi-sector collaborations, including: • Service Connect program for AB109 parole population (coordinated between Behavioral Health, Human Services, probation) • Youth Case Management Team - Behavioral Health Dept. working with juvenile justice and probation/ sheriff's office • Small pilot with pharmacological alcohol treatment within substance abuse agency: pilot demonstrated positive results and convinced health plan to fund an expanded pilot that will look at cost effectiveness for a larger cohort • Housing work through BH - using MHSA dollars to secure housing units for BH clients	• Behavioral Health integration effort recently underway » Behavioral health providers in primary care/ FQHCs, and MH and SUD working together to serve a common population » Organizational level integration by combining MH and SUD departments • Care transitions - coordination between public health and hospitals • Homeless 1000 project: team of housing, primary care, SUD, MH, and PH working together with patients • AB109 (justice) population – transitional housing program (using some county general funds) has shown positive outcomes » "One stop shop" that includes resource center, social services, housing, healthcare (mobile van), mental health • Piloting a joint unit of staff for kids who are engaged in both child welfare and juvenile justice systems	• County stakeholder commission • Many efforts to coordinate mental health and substance abuse, mental health and primary care • Received a CMS Care Transitions grant • Adult & Aging Services coordinating with current long-term care supports program

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Dimension of Whole-Person Care	Los Angeles	San Diego	San Mateo	Santa Clara	Sonoma
Shared Data	• Developing LANES system for health data to allow for transmission of datasets across entities (limited: only for some labs, some utilization, and select ecosystem of providers) • DMH and DHS both implementing electronic health records - but not the same systems (through different vendors) • Enterprise Linkages Project: initiated between DPSS and CEO that involved DHS, children/family, probation, sheriff, and community/senior services. Departments dump data monthly and match data on a person level. Mostly used to look at aggregate data and trends. » Requires a consent in order to use it for individual level care coordination » Retrospective data, not real-time » Electronic Master Person Index (EMPI) allows agencies to match data across departments (DHS, DMH, SUD) with focus on general relief/SSI population	• Health Information Exchange (HIE) between hospitals and primary care (working to include specialty care) • Plan to integrate data within health, behavioral health, and social service sectors • Community Information Exchange (CIE) » Funded from a $1M Innovation Grant; still determining how to finance over time » 2-1-1 providing support and space » Focused on downtown homeless » Hospitals have not invested in CIE yet • Knowledge Integration Program (KIP) - will combine data from providers and agencies; stemmed out of LiveWell to address gaps in accessing services from various agencies; facilitated by having a single IT dept. for the county » Focusing on county providers (500 agencies, 750 programs) and those HHS contracts with » Working to develop a customer info sharing authorization form that will be uniform across the region and master person index » Goal is to have an integrated view based on provider's access rights to facilitate referrals across agencies within that system (either passive or feedback referrals) » Focusing on adult multi-service users - including MH, alcohol/drug, probation, housing, one of the public health datasets, child welfare • Long-term plan (3-5 years) to integrate data across sectors through CIE, KIP, and HIE	• Developing "data mart" - primarily in the health system, funded by Health Plan of San Mateo • Behavioral Health and Probation Departments have a special MOU that allows them to share data when kids enter the juvenile justice for the first time	• Passed legislation last year allowing health system to share data with social services, but lack of will to get it started • Working towards central database shared across health system and behavioral health (and eventually, social services) • Department of Alcohol and Drug Services using a dashboard to collect and analyze key metrics	• Long-term plan to merge SUD and MH databases • From SUD side, unable to share some confidential information back to health system or police dept. • Sharing information, analyzing data on high utilizers, costing out emergency department utilization in Sheriff's department • Local challenge: different screening tool used by BH and health plan

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Dimension of Whole-Person Care	Los Angeles	San Diego	San Mateo	Santa Clara	Sonoma
Financial Flexibility	• Flexibility because most dollars are already under full-risk capitated payment for managed care population • Opportunity to leverage favorable rates for Medi-Cal expansion population • Housing projects funded through multiple mechanisms: » Housing for Health: partially funded through DHS budget (not using any Medicaid dollars at this point) » Project 50: funded with discretionary funds » $400mil from MHSA dollars invested in supportive housing through DMH	• Leveraging multiple sources of funding from diverse sources » Using Live Well as unifying vision for collaborators and compelling message for funders (Live Well is funded by CDC grant and County funds) » Leveraging county funds to draw down federal funding (LIHP) » Significant amount of grant funding (Beacon, CTG, CPPW, CCTP etc.) • Duals demonstration: blended Medicare/ Medicaid funding and braided funding with aging services • Behavioral Health: shifting financial responsibility from the county to health centers and other private sector actors	• Through Duals demo and SNPs, Health Plan of San Mateo is already using funding flexibly • Took most risk in whole state for duals across aid categories (institutionalized, HCBS high, HCBS low, community well) and plan to use risk to invest in upstream interventions like supportive housing for institutionalized or HCBS high groups • Braided funding in BH across multiple examples (e.g. FQHC nurse practitioner in Behavioral Health and Behavioral Health staff in FQHCs) but still challenge of not being able to bill two visits on same day • Measure A County funding has been used for case management & coordination in Service Connect program (through BH)	• Able to fund some projects with county general funds (e.g., Housing 1000 project, BH providers in health clinics) • Braided funding: MH dollars are used to staff BH providers in health clinics • County Measure A funds are a possibility (but a lot of competition for them) • The ACA offers the opportunity for more financial flexibility (more dollars available for Medi-Cal)	• Actively trying to leverage past experience by responding to numerous grant opportunities • Braided funding for mental health patients (using county behavioral health dollars and health center dollars) • Financial flexibility to offer integrated services for SMI population. 40% of budget goes to contracts with community providers for these services • High-cost case management pilot is galvanizing grant resources for under-funded initiatives like care coordination • Way to build whole-person care infrastructure in the county

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