Whole Person Care (WPC) Pilot Program Challenges, Lessons Learned, and Successes: January 2017-June 2018

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Introduction

The UCLA Center for Health Policy Research (UCLA) was selected by DHCS to evaluate the Whole Person Care Pilot Program (WPC). This report highlights self-reported challenges, lessons learned, and successes identified by the 25 WPC Pilots in the Program Year (PY) 2 mid-year and annual and PY 3 mid-year narrative reports, which covered the first 18 months of program activities (January 2017 to June 2018). WPC implementation was staggered between two groups, with Group 1 starting January 2017 and Group 2 starting July 2017. Due to these staggered implementation periods, WPC Pilots in Group 1 (18 of 25) submitted all three reports (PY 2 mid-year, PY 2 annual, and PY 3 mid-year), while WPC Pilots in Group 2 (7 of 25) only submitted PY 2 annual and PY 3 mid-year reports.

A total of 68 reports were analyzed and included: WPC PY 2 mid-year (n=18), PY 2 annual (n=25), and PY 3 (n=25) mid-year narrative reports (N=68). All narrative report descriptions of challenges and success were coded into major themes and sub-themes, then reviewed by at least two members of the UCLA team. The findings were then summarized in this report reflecting the dominant themes in WPC Pilot self-reported challenges, lessons learned, and successes. This report is organized in four sections reflecting these themes, which include (1) identifying, engaging, and enrolling eligible beneficiaries; (2) care coordination; (3) data sharing, information technology, and reporting; and (4) biggest barriers to WPC success.

Not all WPC Pilots provided extensive detail or fully described each challenge or success. The UCLA team used all available information and developed themes, provided examples of types of topics grouped within the theme, and provided specific illustrative examples per theme from various WPC Pilots. Due to data limitations, the ability of the UCLA team to fully describe these topics was often limited.

Whole Person Care Overview

The Whole Person Care Pilot Program is part of California's current Section 1115 Medicaid Waiver called "Medi-Cal 2020," implemented from January 1, 2016 to December 31, 2020. Twenty five Lead Entities (LE) were chosen to implement the WPC Pilots. The Pilots were selected to provide coordinated and integrated medical care, behavioral health and substance use care, and social services to Medi-Cal beneficiaries who repeatedly use multiple and often acute services and have poor health outcomes. WPC Pilots are comprised of partnerships of county agencies, health plans, providers, community-based organizations, and other entities led by a single LE, typically a county health and human service agency. WPC Pilots are responsible for systematically identifying target populations, sharing data, coordinating care, and evaluating improvements in the health of their enrolled populations. WPC Pilots are expected to improve service delivery and health outcomes; enhance sustainability of infrastructure improvements and program interventions; and reduce costs through reductions in avoidable utilization.

WPC Pilots and Projected Enrollment

Characteristics of the 25 unique WPC Pilots are presented in Exhibit 1, including the LE, abbreviated WPC Pilot name, and projected enrollment prior to start of the program. A total of nearly 300,000 individuals were projected for enrollment over the five years of the program, ranging from a low of 250 in Solano to a high of 154,000 in Los Angeles.

Exhibit 1: Whole Person Care Lead Entities, Abbreviated Pilot Program Names, and Projected Enrollment

Lead Entity	Abbreviated Pilot Program Name	Projected Enrollment
Solano County Health and Social Services	Solano	250
Small County Whole Person Care Collaborative (Mariposa and San Benito Counties)	Small County Collaborative	287
Placer County Health and Human Services Department	Placer	450
Monterey County Health Department	Monterey	500
Shasta County Health and Human Services Agency	Shasta	600
Kings County Human Services Agency	Kings	600
Mendocino County Health and Human Services Agency	Mendocino	600
County of Santa Cruz, Health Services Agency	Santa Cruz	625
Napa County	Napa	800
County of San Diego, Health and Human Services Agency	San Diego	1,049
Kern Medical Center	Kern	2,000
San Bernardino County— Arrowhead Regional Medical Center	San Bernardino	2,000
San Joaquin County Health Care Services Agency	San Joaquin	2,255
Ventura County Health Care Agency	Ventura	2,280
County of Sonoma, Department of Health Services Behavioral Health Division	Sonoma	3,040
County of Marin, Department of Health and Human Services	Marin	3,516
City of Sacramento	Sacramento	4,386
San Mateo County Health System	San Mateo	5,000
County of Orange, Health Care Agency	Orange	9,303
Santa Clara Valley Health and Hospital System	Santa Clara	10,000
Contra Costa Health Services	Contra Costa	15,600
San Francisco Department of Public Health	San Francisco	16,954
Alameda County Health Care Services Agency	Alameda	20,000
Riverside University Health System— Behavioral Health	Riverside	38,000
Los Angeles County Department of Health Services	Los Angeles	154,044

Note: Projected enrollment numbers are from Whole Person Care applications and do not reflect later projections or current enrollment estimates.

Identification, Engagement, and Enrollment

WPC Pilots are required to identify and engage eligible Medi-Cal beneficiaries in their county who meet the selection criteria, and enroll them into the WPC program. Each WPC Pilot targets one or more of the following populations: (1) high utilizers of avoidable emergency department use, hospital admissions, or nursing facility placement; (2) individuals with two or more chronic physical conditions; (3) individuals with severe mental illness and/or substance use disorder; (4) individuals experiencing homelessness; (5) individuals at-risk-of-homelessness; and (6) individuals recently released from institutions, including jail or prison.

WPC Pilots employed a wide range of strategies to identify eligible Medi-Cal beneficiaries, including use of administrative and electronic medical record data to identify individuals who meet the Pilot's target population inclusion criteria; referrals from partners such as managed care plans, primary care providers, and clinics; and/or warm hand-offs from health and social service partners. Once eligible Medi-Cal beneficiaries were identified, WPC Pilots sought to engage them in WPC through a variety of modalities, including in-person one-on-one meetings, phone calls, text conversations, and home visits. Once identified and engaged, most WPC Pilots then enrolled eligible Medi-Cal beneficiaries into WPC.[1]

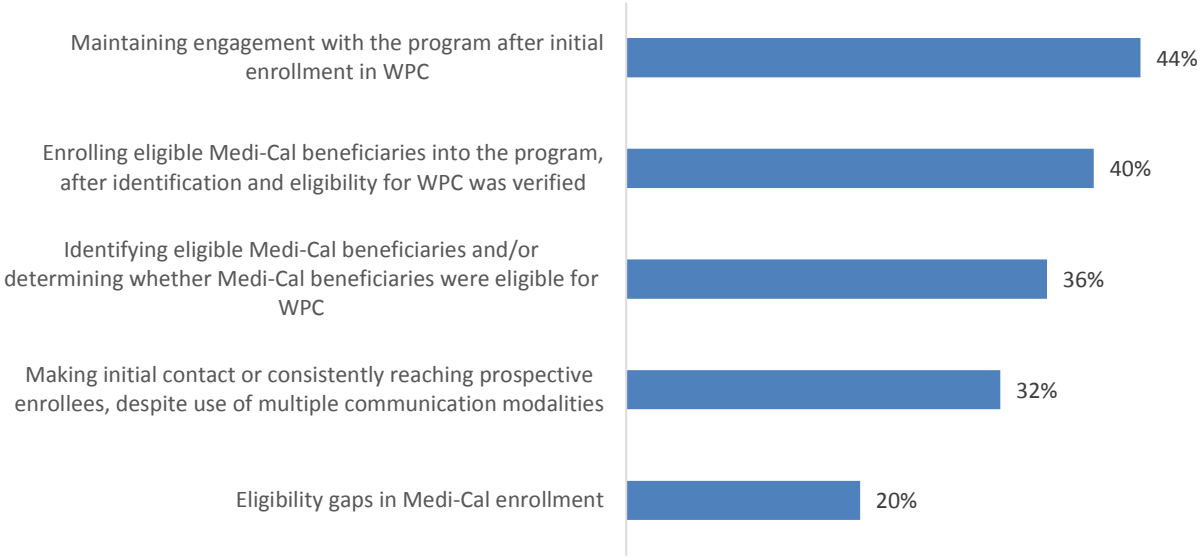
This section summarizes and provides specific examples of WPC Pilot challenges and successes related to identifying, engaging, and enrolling eligible target populations.

Challenges

The five most common themes that emerged from WPC Pilot descriptions of challenges to identifying, engaging, and enrolling eligible target populations were: (1) maintaining engagement with the program after initial enrollment in WPC; (2) enrolling eligible Medi-Cal beneficiaries into the program, after identification and eligibility for WPC was verified; (3) identifying eligible Medi-Cal beneficiaries and/or determining whether Medi-Cal beneficiaries were eligible for WPC; (4) making initial contact or consistently reaching eligible Medi-Cal beneficiaries, despite use of multiple communication modalities; and (5) eligibility gaps in Medi-Cal enrollment (Exhibit 2).

[1] A limited number of WPC Pilots employed an opt-out enrollment strategy and enrolled eligible Medi-Cal beneficiaries prior to engagement.

Exhibit 2: Commonly Identified Challenges in Identifying, Engaging, and Enrolling Prospective Enrollees among WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (N=68).

Nearly half of WPC Pilots (44%; 11 of 25) reported challenges related to maintaining engagement with the program after initial enrollment in WPC. Enrollees may not readily engage with the program due to a diverse array of enrollee-specific behaviors and beliefs that can be challenging to overcome. For example, WPC Pilots reported challenges in building trust and rapport with enrollees; addressing enrollee misperceptions about the services provided through the WPC Pilot Program (e.g., belief that the program would help the enrollee secure housing); and a lack of enrollee readiness to work towards their goals and change their lives (i.e., low self-efficacy and/or activation).

Ten of 25 WPC Pilots (40%) reported difficulty enrolling eligible Medi-Cal beneficiaries into the program, after identification and eligibility for WPC was verified. Many Pilots structured their program to have an intensive outreach and engagement component, to be followed by a more "official" enrollment into WPC. Despite multiple contacts and engagements, eligible Medi-Cal beneficiaries may have declined services or chose to enroll in other similar care coordination or case management programs instead. In early narrative reports, several WPC Pilots noted challenges reaching their initial projected enrollment targets, which were often a result of other implementation challenges (e.g., staffing shortages, unclear referral pathways, and lack of initial partner buy-in).

Over one-third of WPC Pilots (36%; 9 of 25) reported challenges identifying eligible Medi-Cal beneficiaries and/or determining whether Medi-Cal beneficiaries were eligible for WPC. For example, WPC Pilots cited delays in timeliness and availability of eligibility data (e.g., delay in claims from managed care plans to calculate emergency department and inpatient utilization). Additionally, some Pilots identified prospective enrollees who were strong candidates anecdotally and could benefit from WPC, but the Pilot did not have data to support the enrollment decision.

A sizeable number of WPC Pilots (32%; 8 of 25) reported challenges with initial outreach and regular communication with prospective enrollees due to inaccurate or outdated contact information (e.g., phone number, address). This was particularly a challenge amongst the homeless (i.e., no permanent address, transient nature, lost phone) and justice-involved target populations (i.e., unpredictability around timing of release and difficulty contacting/locating after release from jail).

One fifth of WPC Pilots (20%; 5 of 25) reported difficulties managing gaps in Medi-Cal eligibility, also known as Medi-Cal "churn". Medi-Cal enrollment is required for enrollment in WPC; therefore, any lapse in Medi-Cal coverage results in a lapse of WPC enrollment. Medi-Cal "churn" is a problem amongst both prospective and current WPC enrollees. Oftentimes, Medi-Cal beneficiaries are unaware of their lapse in Medi-Cal coverage or need assistance with their renewal applications. Pilots cited efforts to work with appropriate agencies to determine enrollee redetermination dates early to prevent unnecessary "churn".

Specific examples of challenges related to each main category in Exhibit 2 are described in Exhibit 3.

Exhibit 3: Selected Illustrative Examples of Challenges in Identifying, Engaging, and Enrolling Prospective Enrollees, January 2017-June 2018

Challenges Related to Identifying, Engaging, and Enrolling Prospective Enrollees	Examples from Narrative Reports
Maintaining engagement with the program after initial enrollment in WPC	• Enrollees in Kern demonstrated a lack of engagement when their assigned care coordinator was not available; often, enrollees did not feel comfortable working with another member of the care coordination team and were unwilling to share their concerns with care coordinators they did not have an established connection with. • Enrollees in Kings showed a reluctance to re-engage with service providers they had negative experiences with in the past. As a rural county, the Pilot has limited options for certain service and specialty providers.
Enrolling eligible Medi-Cal beneficiaries into the	• San Francisco faced challenges enrolling homeless individuals in WPC as many were Medi-Cal eligible but had not enrolled in Medi-Cal because

Challenges Related to Identifying, Engaging, and Enrolling Prospective Enrollees	Examples from Narrative Reports
program, after identification and eligibility for WPC was verified	they perceived the process as burdensome and complicated. Due to their resistance to enroll in Medi-Cal, San Francisco ultimately could not enroll these individuals into WPC. • Solano emphasized challenges in enrollment as many prospective enrollees declined services after multiple attempts of outreach and engagement. Solano primarily targets high utilizers and individuals with serious mental illness and substance use disorder.
Identifying eligible Medi-Cal beneficiaries and/or determining whether Medi-Cal beneficiaries were eligible for WPC	• Marin expressed challenges with accessing reliable data sources to confirm prospective enrollees' eligibility. Marin noted they often anecdotally know that a prospective enrollee may use multiple systems, but do not have access to those systems' data to support the enrollment decision (e.g., to determine if a prospective enrollee had three or more emergency department visits or inpatient stays). • Los Angeles noted that many individuals in their target population did not know their social security number or date of birth. This prevented frontline staff from being able to quickly verify Medi-Cal status. Although the prospective enrollee appeared to meet WPC eligibility criteria, this delayed the program's ability to move forward seamlessly with enrollment.
Making initial contact or consistently reaching prospective enrollees, despite use of multiple communication modalities	• Riverside emphasized challenges reaching homeless enrollees as many do not have a cell phone and are transient in nature. • San Benito (of Small County Collaborative) experienced difficulty engaging the homeless population and often had to locate prospective enrollees directly on the streets for outreach and engagement attempts.
Eligibility gaps in Medi-Cal enrollment	• Alameda noted Medi-Cal "churn" was exacerbated by targeted eligible Medi-Cal beneficiaries frequently entering and exiting incarceration and moving across county lines. This made it difficult to keep track of redetermination dates and to reach out to provide assistance with submitting Medi-Cal renewal paperwork. • Contra Costa emphasized that roughly 10-20% of their Medi-Cal population experienced Medi-Cal "churn" each month, which is further complicated by the fact that many enrollees were unaware of the lapse in their Medi-Cal coverage.

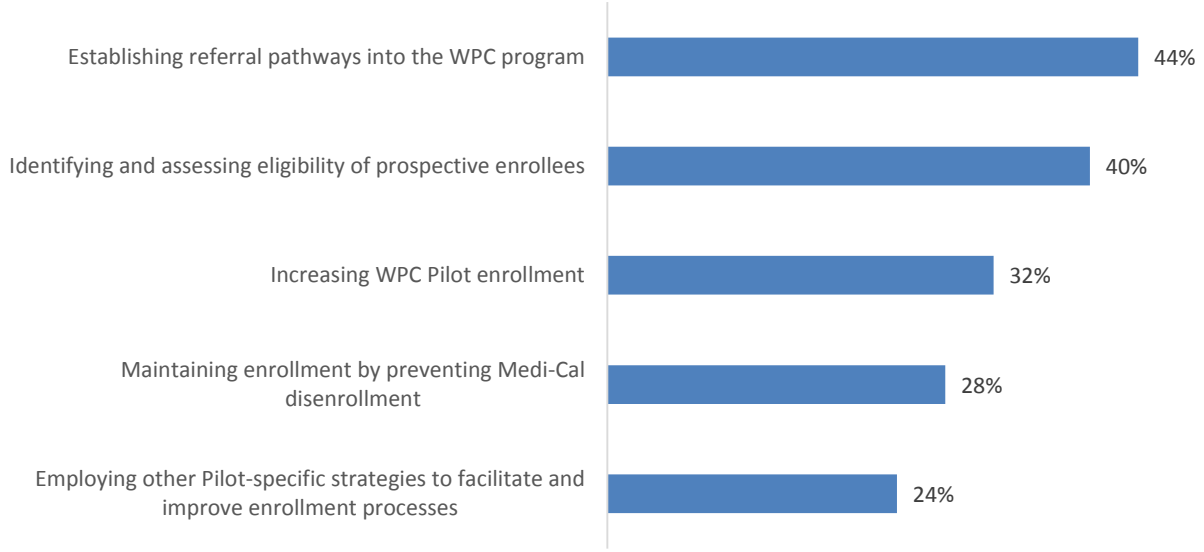
Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Successes

The five most common themes that emerged from WPC Pilot descriptions of successes in identifying, engaging, and enrolling targeted eligible Medi-Cal beneficiaries were: (1) establishing referral pathways into the WPC program; (2) identifying and assessing eligibility of prospective enrollees; (3) increasing WPC Pilot enrollment; (4) maintaining enrollment by preventing Medi-Cal disenrollment; and (5) employing other Pilot-specific strategies to facilitate and improve enrollment processes (Exhibit 4). These successes were often directly the result of

policy and procedure changes that were motivated by the challenges identified in the section above.

Exhibit 4: Commonly Identified Successes in Identifying, Engaging, and Enrolling Prospective Enrollees among WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (N=68).

Nearly half of WPC Pilots (44%, 11 of 25) reported successes related to the establishment of referral pathways, which were the processes through which WPC enrollees were referred by providers, partners, and other external sources into the WPC program and connected to services that addressed their needs. WPC Pilots developed critical partnerships and specific protocols to facilitate referrals into the program. Commonly identified successes in this area included increased community awareness of WPC; formalized contracts with community partners; and creation of formal guidelines and protocols for referring agencies that outlined WPC Pilot goals and enrollment criteria.

Ten of 25 WPC Pilots (40%) reported successes related to the identification and eligibility assessment of eligible Medi-Cal beneficiaries, which allowed WPC Pilots to better understand their Pilot's target population. Examples of successes in this area included expansion of target populations to increase the number of prospective enrollees; improved strategies for rapidly identifying and assessing prospective enrollees (i.e., inclusion of client contact information in eligibility data, ability to share target population lists across partners); and use of in-person meetings with partners to identify and strategize around high-need prospective enrollees.

Nearly one third of WPC Pilots (32%, eight of 25) reported successes in increasing WPC Pilot enrollment, which largely related to Pilots meeting or coming close to their projected enrollment numbers. Improvements in enrollment were a result of many implementation factors including increased staff support, established referral pathways, and familiarity with the program.

Seven of 25 WPC Pilots (28%) reported successes in maintaining enrollment by preventing Medi-Cal disenrollment. For example, Pilots established relationships with human services agencies to better understand enrollees' Medi-Cal coverage lapses through improved data sharing, which allowed Pilots to proactively outreach to enrollees for Medi-Cal reinstatement.

One fourth of WPC Pilots (24%, six of 25) employed other Pilot-specific strategies to facilitate and improve the enrollment process for both frontline staff and eligible Medi-Cal beneficiaries. Examples included expanding responsibilities of street outreach teams to enroll eligible Medi-Cal beneficiaries into WPC and developing electronic forms within the Pilot's care management software to guide care coordinators through necessary steps to ensure efficiency in enrollment.

Specific examples of successes related to each main category in Exhibit 4 are described in Exhibit 5.

Exhibit 5: Selected Illustrative Examples of Successes in Identifying, Engaging, and Enrolling Prospective Enrollees, January 2017-June 2018

Successes Related to Identifying, Engaging, and Enrolling Prospective Enrollees	Examples from Narrative Reports
Establishing referral pathways into the WPC program	• Alameda executed formal contracts with partners, which provided improvements to referrals and linkages to other service providers. • Napa developed a "care coordination collaborative" to create and strengthen referral pathways with housing, health, and other community partners. A key process in the collaborative is to dissect case studies of shared enrollees to strategize how to best provide wrap-around services.
Identifying and assessing eligibility of prospective enrollees	• San Bernardino obtained prospective enrollee data from a number of WPC partners, including behavioral health and public health departments, and managed care plans, and made these data available to Pilot staff to access reliable information for outreach and engagement activities. • Santa Cruz participated in meetings with two local safety-net hospitals to identify and better understand high utilizers of the emergency department and inpatient services. These meetings facilitated Santa Cruz's ability to identify and assess eligibility of prospective enrollees on the spot, through in-depth discussions.
Increasing WPC Pilot enrollment	• Placer was successful in surpassing their enrollment goals for the time period through June 2018 to make progress towards their projected enrollment.

Successes Related to Identifying, Engaging, and Enrolling Prospective Enrollees	Examples from Narrative Reports
	• San Mateo reported satisfaction with their enrollment numbers and their ability to provide a number of services to enrollees including behavioral health, medical services, housing assessments, and transportation.
Maintaining enrollment by preventing Medi-Cal disenrollment	• Contra Costa worked with a local partner, the Employment and Human Services Division of Contra Costa County, to access Medi-Cal eligibility information to better understand enrollee lapses in Medi-Cal coverage and reduce enrollee loss from the Pilot program due to these lapses. • San Bernardino was able to utilize an electronic feed from the County's Transitional Assistance Department to increase efficiency in determining and maintaining Medi-Cal eligibility of WPC enrollees.
Employing other Pilot-specific strategies to facilitate and improve enrollment processes	• Riverside placed nurses in probation offices and jail systems to screen for prospective enrollees; these nurses also helped facilitate warm hand-offs and direct referrals of prospective enrollees recently released from incarceration to Pilot staff. • Due to San Diego's late start at enrollment in the Pilot, San Diego consciously engaged partners in an "early enrollment and identification process," which engaged prospective enrollees prior to official WPC implementation. This intentional process strengthened the Pilot's relationship with future partners and improved understanding and enhanced communication about Pilot services to support future enrollees.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Care Coordination

Care coordination involves "deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care" [1]. Acknowledging historic structural, operational, regulatory, financial, and cultural challenges to cross-sector care coordination, and challenges to engaging low-income, high-risk populations in care, the WPC Pilot Program required WPC Pilots to invest not only in care coordination, but in development of administrative, delivery systems, and data sharing infrastructure necessary to support provision of comprehensive, patient-centered, and effective coordination of care to target beneficiaries.

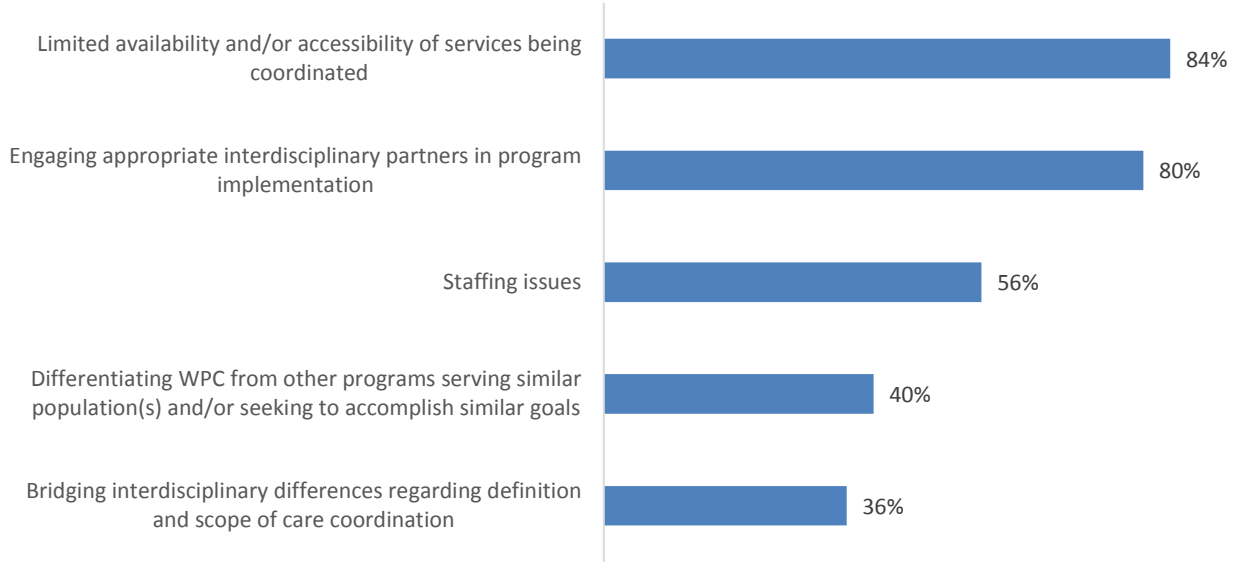
WPC Pilots each developed their own definition of care coordination to guide Pilot activities. While practices varied from Pilot to Pilot, typically a care coordinator with the assistance of a multidisciplinary team worked to assess the enrollee, develop a care plan, refer the enrollee to needed services, and build enrollee skillsets to eventually coordinate their own care to the extent possible.

This section summarizes and provides specific examples of WPC Pilot challenges and successes related to care coordination, as well as lessons learned during the implementation process.

Challenges

WPC Pilots were asked to report challenges to implementing care coordination. The five most common themes that emerged from Pilot descriptions of challenges were: (1) limited availability and/or accessibility of services being coordinated, particularly housing; (2) engaging appropriate interdisciplinary partners in program implementation; (3) staffing issues (e.g., recruitment, training, retention, turnover); (4) differentiating WPC from other programs serving similar population(s) and/or seeking to accomplish similar goals; and (5) bridging interdisciplinary differences regarding definition and scope of care coordination (Exhibit 6).

Exhibit 6: Commonly Identified Challenges in Care Coordination among WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (N=68).

Over three-fourths of WPC Pilots (21 of 25; 84%) described care coordination challenges related to limited availability and/or accessibility of services for enrollee referrals. WPC Pilots most commonly referenced housing-related issues, including: long wait times for existing permanent housing stock; limited housing options available within the county; poor quality and fit for enrollees among the available housing units; and how the lack of housing prevented other desired health and social outcomes among enrollees. Additional examples of challenges WPC Pilots discussed regarding limited availability and/or accessibility of services included: increased referrals on an already overburdened system prevented access to needed services for WPC enrollees and a lack of specialty care, substance use, and mental health treatments within county limits.

Four-fifths of WPC Pilots (20 of 25; 80%) identified difficulty engaging appropriate interdisciplinary partners in program implementation as a barrier to care coordination. For example, multiple WPC Pilots reported that partners were unwilling or hesitant to engage due to their competing priorities with other programs or initiatives. Initially, WPC Pilots mentioned limited trust and buy-in from partners to the WPC program.

Over one half of WPC Pilots (14 of 25; 56%) identified staffing issues including recruitment, training, retention, and turnover as a barrier to care coordination. Multiple Pilots explicitly attributed staffing challenges to cumbersome county hiring and/or contracting processes such as background checks or requirements for open search that made it difficult to quickly fill key administrative and/or frontline positions. These challenges required WPC Pilots to plan far ahead when developing project timelines, which was challenging early in the implementation process.

More than one third of WPC Pilots (10 of 25; 40%) reported enrollees, partners, and the community experienced some difficulty in differentiating WPC from other programs providing similar services and/or seeking to accomplish similar goals. Care coordination and case management services were often offered through a variety of agencies and organizations, such as behavioral health departments and managed care plans, which created confusion regarding WPC scope and concern around the WPC requirement for non-duplication of services.

Lastly, nine of 25 WPC Pilots (36%) experienced challenges overcoming interdisciplinary differences regarding the scope and definition of care coordination. For example, various agencies used similar vocabulary when discussing care coordination, but ultimately found they had different assumptions of what activities actually constitute effective care coordination. In order to ensure all partners met the WPC Pilot's requirements for care coordination, Pilots had to develop common definitions and/or more specifically outline their expectations for care coordination functions.

Specific examples of challenges related to each main category in Exhibit 6 are described in Exhibit 7.

Exhibit 7: Selected Illustrative Examples of Challenges in Care Coordination, January 2017-June 2018

Challenges Related to Care Coordination	Examples from Narrative Reports
Limited availability and/or accessibility of services being coordinated	• Alameda faced challenges with an increasingly tight housing market, noting a significant decline in the number of available units in the private market that could be utilized by enrollees with vouchers. Furthermore, Alameda noted that when housing navigators found a housing opportunity they often seized it,

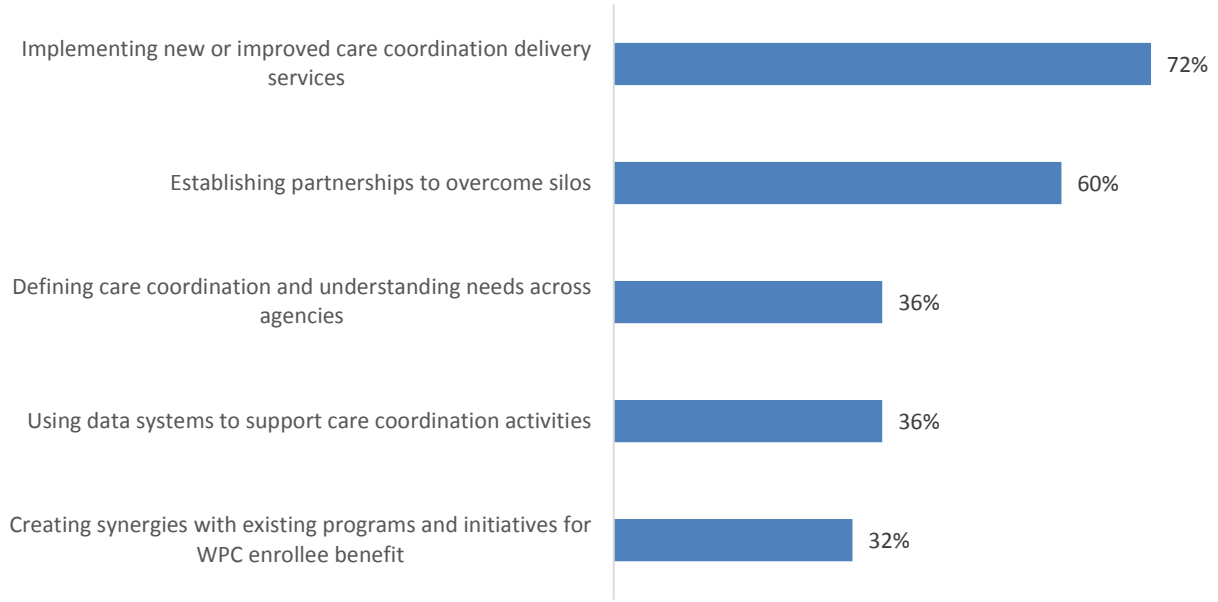
Challenges Related to Care Coordination	Examples from Narrative Reports
	despite it not being the best potential fit for the enrollee, which resulted in a less stable housing situation in the long run. • San Francisco emphasized the challenge of not having culturally appropriate services available to connect enrollees to in the first place. San Francisco believed traditional health and social services within large systems of care were often not the "right fit" for homeless enrollees.
Engaging appropriate interdisciplinary partners in program implementation	• Sonoma faced challenges in building relationships with partners and navigating the local political climate in order to accomplish care coordination activities. • Santa Clara identified challenges with ensuring accountability given the numerous agencies and departments involved in their WPC Pilot. Standardization of services, processes, and communication strategies helped to facilitate partner engagement, but Santa Clara still cited ongoing challenges coordinating across partners and gaining partner buy-in.
Staffing issues	• Los Angeles described complex hiring and contracting policies within their county as inhibiting their ability to rapidly build program capacity and onboard staff. • San Benito and Mariposa (Small County Collaborative) discussed the difficulty in recruiting and retaining skilled professionals in rural geographic locations.
Differentiating WPC from other programs serving similar population(s) and/or seeking to accomplish similar goals	• When Sacramento began outreach and engagement efforts to prospective enrollees, they quickly learned that prospective enrollees did not understand how their WPC Pilot Program differed from other navigation programs offered by city and county housing providers, hospitals, and community clinics. • Santa Cruz encountered challenges managing the interactions of various case management programs situated in the community and within their own Health Services Agency. The presence of multiple case management programs led to confusion, as well as fear of duplication and competition for scarce resources amongst participating agencies.
Bridging interdisciplinary differences regarding definition and scope of care coordination	• San Mateo emphasized how siloed systems of care resulted in different regulatory requirements and care coordination standards within each department. To implement WPC, San Mateo had to work across departments to develop a shared understanding of what care coordination means and how to effectively navigate each of the various departments' specific requirements. • Monterey discovered that although many partners employed "case managers," in practice, the definition of case management and associated scope of work varied significantly across sectors.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Successes

WPC Pilots were asked to report successes in implementing care coordination. The five most common themes that emerged from Pilot descriptions of successes were: (1) implementing new or improved care coordination delivery services; (2) establishing partnerships to overcome silos; (3) defining care coordination and understanding needs across agencies; (4) using data systems to support care coordination activities; and (5) creating synergies with existing programs and initiatives for WPC enrollee benefit (Exhibit 8).

Exhibit 8: Commonly Identified Successes in Care Coordination among WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (N=68).

Roughly three-fourths of WPC Pilots (18 of 25; 72%) reported successes related to implementation of new or improved care coordination services; many of these efforts focused on improvements in the day-to-day activities of frontline staff. Commonly identified examples of successes within the delivery of care coordination services included: organizing regular case conferences with partners and managed care plans to discuss high-need enrollees; prioritization of services or housing for WPC enrollees including reserved appointments, set-aside vouchers; and effective communication across the entire care team.

Additionally, 15 of 25 WPC Pilots (60%) reported successes in establishing partnerships to overcome silos. Frequently WPC Pilots described working with partners in new ways that improved understanding of mutual goals for shared clients (e.g., warm handoffs of enrollees after an emergency department visit, direct communication through electronic platforms). WPC Pilots emphasized proactive and consistent communication amongst partners, and formalized contracts to facilitate implementation of care coordination activities among partners with historically limited interaction.

Over one third of WPC Pilots (nine of 25; 36%) reported successes in defining care coordination and understanding care coordination needs across agencies including alignment of enrollee assessment tools across partners, tracking of metrics, and establishment of referral pathways.

Several WPC Pilots developed formal and shared definitions within their partner networks for care coordination that outlined specific responsibilities by agency. Often this was facilitated by the WPC Pilot initiating an opportunity such as organizing a meeting or listening session for partners to work together to develop a common definition or list of required care coordination activities.

Nine WPC Pilots (36%) had successes related to using data systems to support care coordination activities. Many WPC Pilots reported having procured or being in the process of procuring care management platforms, which helped to streamline important care coordination activities and share relevant enrollee information amongst multiple users involved in the enrollee's care.

Lastly, eight WPC Pilots (32%) reported successes for WPC enrollees as a result of effectively utilizing synergies with existing programs and initiatives, particularly because many programs have similar goals and provide care to the same populations. Typically, these successes involved the Pilots working with other programs to identify and delineate their respective roles and responsibilities with those WPC enrollees.

Specific examples of successes related to each main category in Exhibit 8 are described in Exhibit 9.

Exhibit 9: Selected Illustrative Examples of Successes in Care Coordination, January 2017-June 2018

Successes Related to Care Coordination	Examples from Narrative Reports
Implementing new or improved care coordination delivery services	• San Bernardino held monthly "Whole Person Care Accountability Review" (WAR) conferences (i.e., detailed, complex case reviews) with the program manager. In these meetings, each enrollee was individually studied and discussed amongst the care team. WAR conferences have been successful in developing individual action plans and identifying barriers to care, such as inefficient communication pathways. • Ventura had a daily huddle to support team-based care. In the daily huddle, teams reviewed new enrollees, integrated care plans, recent emergency department visits and hospital discharges, and priority and "stuck" cases. Additionally, the huddles provided an opportunity for on the spot training for brief topics, as issues arose in the field.
Establishing partnerships to overcome silos	• Marin developed a strategic partnership with their local housing authority to set aside vouchers dedicated to WPC enrollees referred through the coordinated entry system. • Orange created a WPC website and central email "mailbox" to address issues as they arose and provide guidance to participating partners. This simple tool has allowed coordination across programs and organizations.

Successes Related to Care Coordination	Examples from Narrative Reports
Defining care coordination and understanding needs across agencies	• San Mateo developed a formal definition of care coordination that was approved by the operating committee for use across the entire San Mateo Health System. • Alameda conducted group listening sessions with their partners to examine challenges and identify opportunities to develop successful care coordination methods.
Using data systems to support care coordination activities	• Contra Costa developed a case management platform within their electronic health record (EHR). Case managers accessed documentation and care plans directly from the EHR system, and all providers had access to enrollee and case manager contact information. This coordinated documentation module ensured care coordination across all systems of care. • Santa Cruz used their County's long established Health Information Exchange to adapt the system's existing case management and referral management application to support the specific needs of their Pilot.
Creating synergies with existing programs and initiatives for WPC enrollee benefit	• San Diego worked with their managed care plans to develop a "Care Coordination Matrix" which defined how each health plan provided care management and identified people for inclusion in their care management programs. The matrix also included key contact information for individual care management services. This tool assists in ensuring coordinated care across WPC and the individual health plans. • In San Mateo, complex case conferences revealed and resolved overlap in services offered by the care coordination team and Full Service Partnerships (FSPs), a separate service that provides comprehensive mental health services for adults diagnosed with severe mental illness. It was determined that San Mateo would assign enrollees who were connected to FSPs to a WPC care coordinator only if there was a need. In addition, the FSP programs could receive care coordination support from San Mateo as needed for specific cases.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Data Sharing, Information Technology, and Reporting

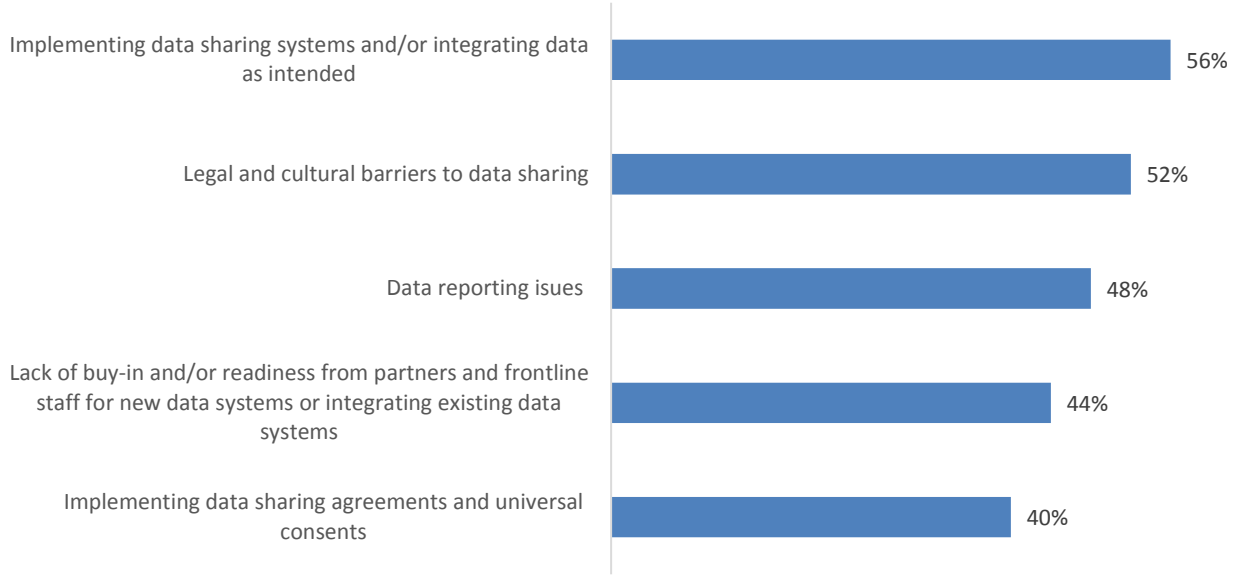
The WPC program required WPC Pilots to describe: (1) how data was shared with partners, (2) methodology for sharing Personal Health Information, particularly mental health, and/or substance use disorder information, (3) use of tools to support data sharing, and (4) timeline and implementation plan for developing the data sharing infrastructure. Additionally, the WPC program required WPC Pilots to collect data for analysis and reporting in order to assess WPC program interventions, strategies, participant health outcomes, return on investment, ongoing quality improvement, and monitoring of performance. WPC Pilots were allowed to adjust already existing processes, identify new and existing data sources, and integrate new tools to improve data collection and reporting. [2, 3]

This section summarizes and provides specific examples of WPC Pilot challenges and successes in data, information sharing, and reporting, as well as related lessons learned.

Challenges

WPC Pilots were asked to report challenges related to data sharing, information technology, and reporting. The five most common themes that emerged from Pilot descriptions of challenges were: (1) implementing data sharing systems and/or integrating data as intended; (2) legal and cultural barriers to data sharing; (3) data reporting issues; (4) lack of buy-in and/or readiness from partners and frontline staff for using new data systems or integrating existing data systems; and (5) implementing data sharing agreements and universal consents (Exhibit 10).

Exhibit 10: Commonly Identified Challenges in Data, Information Sharing, and Reporting among WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (N=68).

Over half of WPC Pilots (14 of 25; 56%) cited inability to implement data sharing systems and/or integrate data as intended as a barrier to data sharing. WPC Pilots noted that data sharing often required integrating data from disparate sources. For example, frontline staff to assimilate data from different electronic health records or administrative databases to comprehensively understand the needs of an enrollee in order to make an informed care decision on what the enrollee may require. Vendor delays, designing and/or purchasing technology that allowed for real-time data storage, and access by multiple agencies and users were described as challenges, both in terms of cost and in terms of the identification and selection process.

Many WPC Pilots (13 of 25; 52%) identified legal and cultural barriers to data sharing such as risk aversion, differing interpretations of laws and regulations. Fear of violating the Health Insurance Portability and Accountability Act or other data privacy laws was cited as contributing to a reluctance to share data, even across departments within the same agency. WPC Pilots described misunderstandings and differing interpretation among partners regarding what data could be legally shared as a barrier to successful data sharing. In particular, roughly one third (nine of 25; 36%) of WPC Pilots explicitly referenced privacy restrictions under Title 42 of the Code of Federal Regulations (CFR) Part 2 as complicating efforts to share substance abuse treatment data, and necessitating development of new referral, intake, and/or consent forms.

Just under half of WPC Pilots (12 of 25; 48%) reported issues with data reporting including tracking care coordination activities and services provided through WPC. Multiple WPC Pilots reported challenges in ensuring consistency of data being collected across partners; WPC Pilots noted a considerable effort to reconcile different data sources and develop new documentation strategies.

Almost half of WPC Pilots (11 of 25; 44%) discussed challenges around a lack of buy-in and/or readiness from partners and frontline staff for new data systems or integrating existing data systems. Many partners had different and very particular data needs and it was challenging to find a platform that met everyone's specifications. Frontline staff were resistant to accessing multiple systems in order to input required information for reporting and tracking of care coordination services.

Lastly, ten Pilots (40%) expressed difficulty implementing data sharing agreements such as Memorandums of Understanding (MOUs) and Business Associate Agreements (BAAs), and establishing a universal consent agreement across partners and county agencies. Discrepancies across agencies and partners in preferred language, access, and protections for the enrollee were common barriers.

Specific examples of challenges related to each main category in Exhibit 10 are described in Exhibit 11.

Exhibit 11: Selected Illustrative Examples of Challenges in Data, Information Sharing, and Reporting, January 2017-June 2018

Challenges Related to Data, Information Sharing, and Reporting	Examples from Narrative Reports
Implementing data sharing systems and/or integrating data as intended	• Solano underestimated the amount of time it would take to study available options and choose a data sharing platform that would best fit the Pilot; as a result, enrollment began without a formal structure to collect enrollee data.

Challenges Related to Data, Information Sharing, and Reporting	Examples from Narrative Reports
	• Kern expressed challenges identifying a data sharing platform that would work well with external partners, while simultaneously integrating with their own "antiquated" EHR. Kern Medical Center was in the process of selecting a new EHR; as a result, Kern delayed commitment to a stand-alone care management system with hopes they could strategically think about integrated capabilities in the future.
Legal and cultural barriers to data sharing	• Alameda noted a general culture of concern amongst partners about information sharing, privacy, and confidentiality restrictions. This greatly inhibited partners' willingness to collaborate and consider innovative solutions for care coordination issues. • Napa underwent significant negotiation and strategized with county privacy and security staff to access the data needed to coordinate care for the Pilot's enrollees and adequately report metrics.
Data reporting issues	• San Francisco faced challenges with effectively capturing and tracking complex care coordination encounters by a wide range of providers due to technical and administrative issues. Many providers had to manually complete paper encounter forms, which was then dependent on the safe transport, digitization, and storage of physical encounter forms containing private health information. Inconsistent data entry and a manual data process limited San Francisco's ability to report accurately. • Partners in Kings faced competing priorities for time and resources and often considered metric reporting to be of low importance; as a result, metrics were reported to the Pilot somewhat sporadically.
Lack of buy-in and/or readiness from partners and frontline staff for new data systems or integrating existing data systems	• Riverside had multiple data systems to track and document services; nurse case managers were often required to look at up to three different systems in order to view complete records, demonstrating lack of readiness for data integration. • Systems of care across the San Mateo health system use various electronic health records and case management systems for the same enrollees with no clear communication pathways across the systems.
Implementing data sharing agreements and universal consents	• Contra Costa spent more than 18 months to finalize an MOU with their human services department to share Medi-Cal eligibility data to facilitate program enrollment. • Marin attempted to develop a single and comprehensive Release of Information (ROI) for the program; however, they had challenges in successfully integrating the requirements outlined in 42 CFR Part 2.

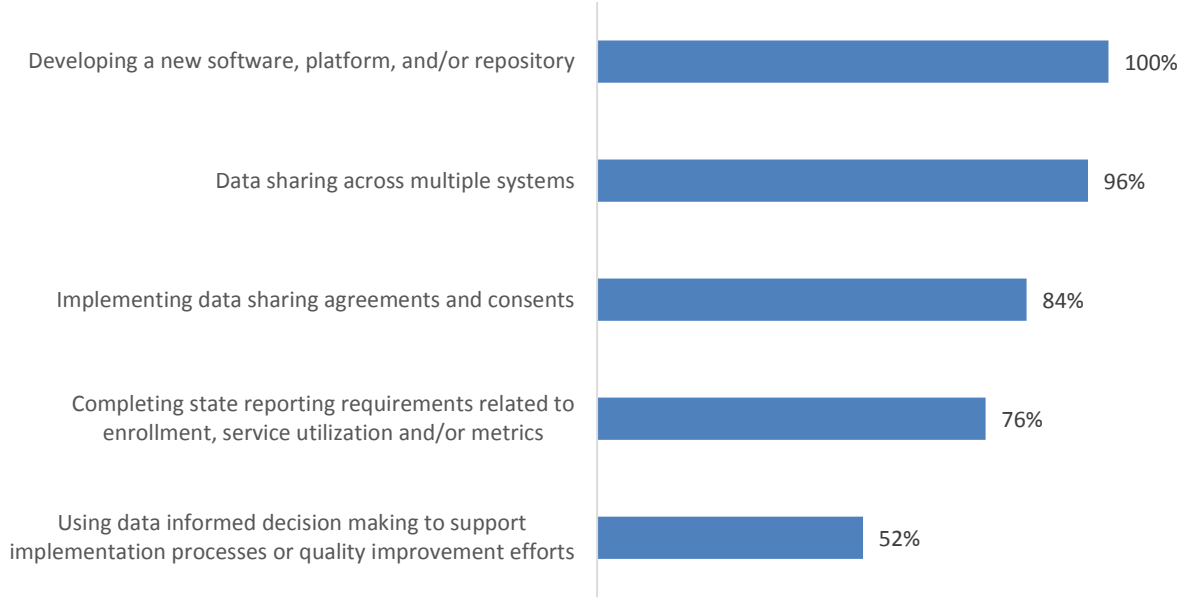
Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Successes

WPC Pilots were asked to report successes related to data sharing, information technology, and reporting. The five most common themes that emerged from Pilot descriptions of successes were: (1) developing a new software, platform, and/or repository; (2) data sharing across multiple systems; (3) implementing data sharing agreements and consents; (4) completing state reporting requirements related to enrollment, service utilization and/or metrics; and (5) using

data informed decision making to support implementation processes or quality improvement efforts (Exhibit 12).

Exhibit 12: Commonly Identified Successes in Data Sharing, Information Technology, and Reporting among WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (N=68).

All 25 WPC Pilots (100%) reported successes in working towards developing a new software, platform, and/or repository. More specifically, 13 Pilots (52%) described success in developing a new care management platform; nine Pilots (36%) reported utilizing temporary data systems while longer-term solutions were still being developed; eight Pilots (32%) identified successes in moving forward with procurement processes for data systems; and seven Pilots (28%) reported expanding functionality within existing systems including developing additional forms and prompts within the EHR (data not shown in Exhibit).

The majority of WPC Pilots (24 of 25; 96%) reported successes in sharing data across multiple systems, particularly with Medi-Cal managed care organizations, local homeless management information systems, substance use disorder programs, and county behavioral health departments. When available technology infrastructure or regulatory permissions did not permit electronic sharing of data across multiple partners, several WPC Pilots identified in-person data sharing as a "workaround". For example, during in-person meetings, frontline staff would have the opportunity to share hard copies of important documents and details of important interactions and conversations they had with the enrollee.

A total of 21 WPC Pilots (84%) identified successes related to implementing data sharing agreements (e.g., MOUs, BAAs) and consents with WPC partners. Many WPC Pilots found data sharing agreements and universal consents to be the foundation necessary for effective referral pathways and truly coordinated care.

Roughly three-fourths of WPC Pilots (76%; 19 of 25) also reported successes in meeting external reporting requirements. For example, WPC Pilots ensured timely submission of enrollment and metrics from partners. Oftentimes, WPC Pilots were reliant on partners to collect the necessary data, a process which was subject to confusion and inconsistency on how to appropriately calculate metrics. WPC Pilots were able to overcome these problems by working with partners to ensure standardized reporting of outcome metrics (e.g., Pilots developed and encouraged partners to use specific templates to submit their data).

Finally, more than half of WPC Pilots (52%; 13 of 25) reported using data informed decision making to support implementation processes or quality improvement efforts. For example, WPC Pilots utilized high risk notifications when enrollees checked into the emergency department, and provided dashboards to frontline staff to help track enrollee progress on relevant metrics. This data allowed frontline staff and management to make real time strategic and informed decisions regarding enrollees' care.

Specific examples of successes related to each main category in Exhibit 12 are described in Exhibit 13.

Exhibit 13: Selected Illustrative Examples of Data Sharing, Information Technology, and Reporting Successes among WPC Pilots, January 2017-June 2018

Successes Related to Data Sharing	Examples from Narrative Reports
Developing a new software, platform, and/or repository	• Los Angeles implemented a new care management platform, CHAMP, which allowed the care coordination team to capture enrollment data, track enrollee encounters, and create/modify each enrollee's comprehensive care plan. • Mendocino and many of their partners were awarded a community grant to implement the case management system called Vertical Change. Implementation was planned for early 2019.
Data sharing across multiple systems	• Kern successfully partnered with their sheriff's department for data sharing to identify eligible Medi-Cal enrollees and locate them upon release from incarceration. The sheriff's department provided the Pilot with a complete list of inmate releases on a daily basis. • Sacramento had bi-directional and real-time data sharing with their managed care plan, Molina. This data sharing relationship was facilitated by weekly operational meetings which were held with all participating staff to review processes, discuss status of members, and provide updates regarding Molina's referrals into WPC.

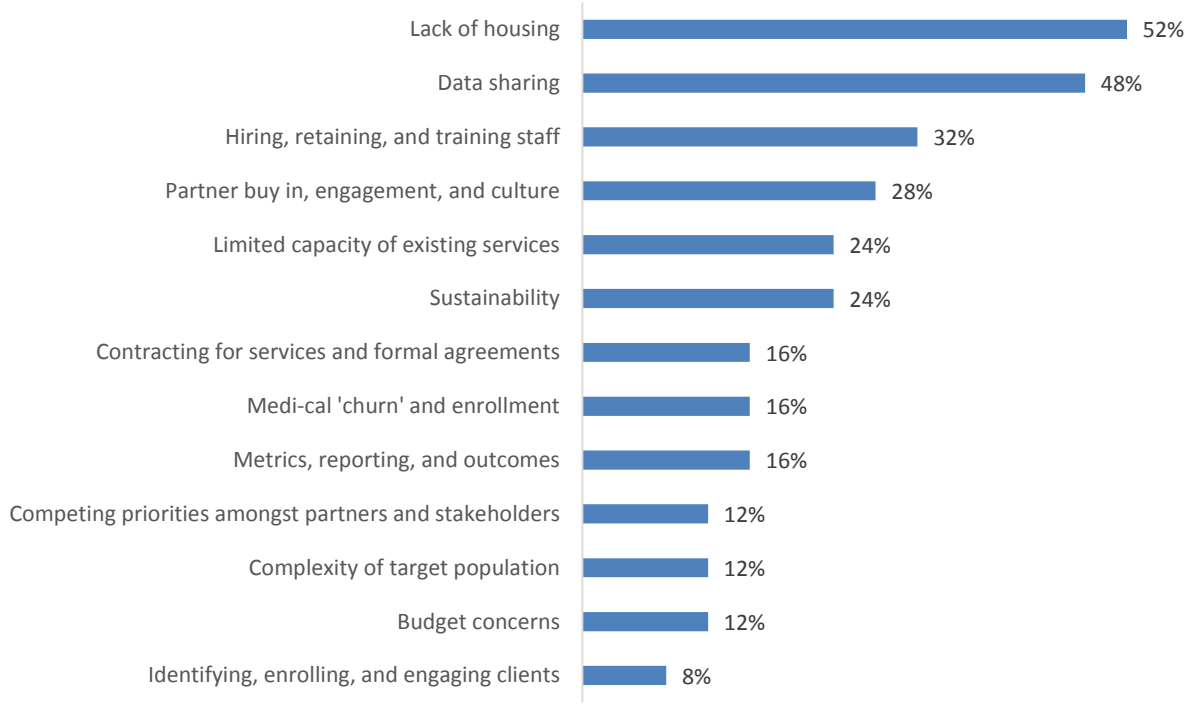
Successes Related to Data Sharing	Examples from Narrative Reports
Implementation of data sharing agreements and consents	• Shasta implemented a workflow model that includes having the prospective enrollee sign an ROI as part of the initial referral packet. Shasta found that having the ROI signed at the outset allows for a more coordinated approach to eligibility determination. • Marin increased the number of partners included on the Pilot's ROI, and recently succeeded in having Marin General Hospital's Compliance Office join and actively participate in the Pilot. This partnership allowed case managers to coordinate with hospital staff in identifying prospective enrollees while they were still in the hospital and improved the development of discharge plans.
Completing state reporting requirements related to enrollment, service utilization and/or metrics	• Due to successful data sharing with their Medi-Cal managed care plan and behavioral health department, Ventura was able to successfully calculate outcome metrics. Ventura noted this was critical because only 40% of emergency department and inpatient utilization took place within Pilot-affiliated hospitals, where the Pilot could access information through their Cerner EHR. • Orange successfully engaged all providers to submit enrollment data on a regular basis to the Pilot team. Although the process was manual, they set clear targets for an electronic coordinated system to come online.
Using data informed decision making to support implementation processes or quality improvement efforts	• Los Angeles published a monthly enrollment dashboard distributed to all program teams and Pilot stakeholders. This dashboard showed several data elements such as monthly enrollments, newly enrolled that month, and cumulatively enrolled to date. Additionally, Los Angeles developed a short weekly dashboard that shows caseload and care plan completion by Community Health Worker or Medical Case Worker. • San Francisco integrated the California multiple encounter dataset into their coordinated care management system in order to determine in real-time if a prospective enrollee is on Medi-Cal or not. This also allowed staff to ascertain which of their enrollees' Medi-Cal enrollment was about to expire or who should be assessed for eligibility.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Biggest Barriers to WPC Pilot Program Success

WPC Pilots were asked to identify what they perceived as the most significant barrier to success of their WPC Pilots. Some Pilots reported only one and others reported more than one significant barrier. Pilots that reported multiple barriers did not rank them. Therefore, all barriers are reported. Pilots identified housing and data sharing as the top two barriers to success (Exhibit 14).

Exhibit 14: Most Significant Barriers to Whole Person Care Pilot Program Success reported by WPC Pilots, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the biggest barrier at least once in any of the three reports (N=68).

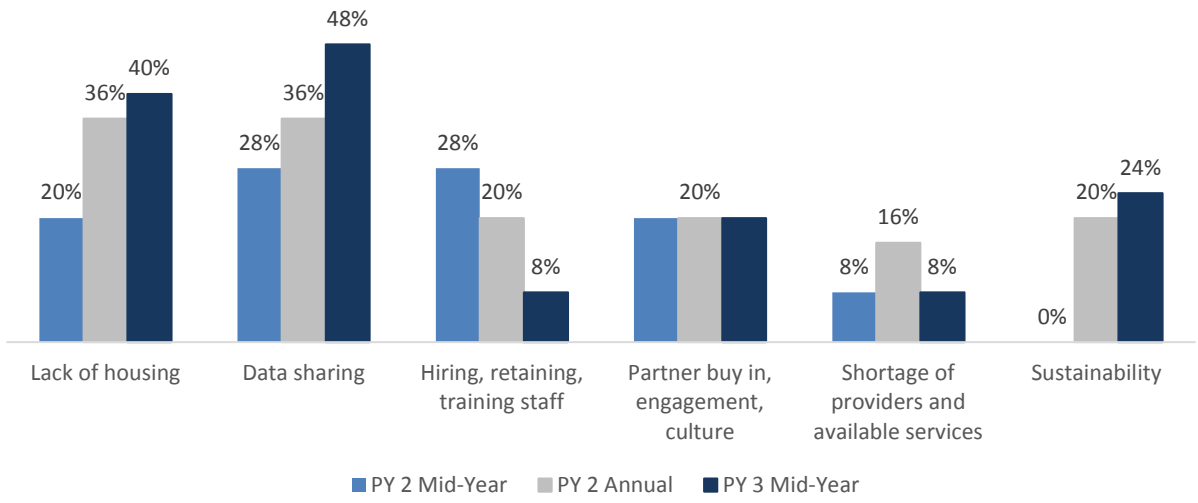
Insufficient housing inventory was identified by most WPC Pilots (13 of 25, 52%) as the biggest barrier to success. WPC Pilots described increasing costs of existing housing stock and inadequate supply of all types of housing, including temporary, permanent, and supportive housing. These problems challenged their efforts to meet enrollees' social service needs and achieve other Pilot goals such as improved health, and continuity of care. These themes were common across all Pilots, even if the Pilot's target population did not include those who were homeless and/or at-risk of homelessness.

WPC Pilots also identified difficulty sharing data with partners as a major barrier to WPC implementation (12 of 25; 48%). Examples of challenges related to data sharing included: reassuring partners that data sharing would not violate confidentiality and privacy regulations and that the mutual benefits outweigh the risks; addressing potential "turf" issues related to perceived "ownership" of the data; and logistical barriers and cost of developing a single, automated data sharing system/source. Several WPC Pilots expressed concern that data sharing issues may persist, despite early gains in established policies and procedures, and buy-in from some but not all partners around necessary scope for data sharing.

Additional barriers reported by WPC Pilots included: staffing challenges related to county hiring timelines and contracting processes, and retaining staff once hired (eight of 25; 32%); gaining partner buy-in and engagement for care coordination (seven of 25; 28%); limitations in access due to shortage of specialist, substance use and mental health providers, and housing and other social service (six of 25; 24%); and planning for sustainability (six of 25; 24%).

There were differences in common themes mentioned by reporting period (Exhibit 15). Lack of housing and data sharing barriers were more frequently reported in PY 2 annual and PY 3 mid-year reports, as time passed and the number of WPC Pilots that implemented WPC increased. By contrast, frequency of challenges related to partnership buy-in, engagement, and culture remained relatively stable in all reports, and the prevalence of challenges related to hiring, retaining, and training staff decreased.

Exhibit 15: Biggest Barriers to Whole Person Care Success among WPC Pilots, by Reporting Period, January 2017-June 2018



Sources: Whole Person Care Program Year 2 Mid-Year (n=18), Program Year 2 Annual (n=25), and Program Year 3 Mid-Year Narrative Reports (n=25).

Summary and Next Steps

WPC Pilots employed a wide variety of strategies to identify, engage, and enroll eligible Medi-Cal beneficiaries into WPC. While WPC Pilots most often cited challenges related to maintaining engagement after initial enrollment in WPC services, WPC Pilots also reported successes in establishing referral pathways and in assessing WPC eligibility for prospective enrollees. Furthermore, identification, engagement, and enrollment processes were often modified and adapted once the WPC Pilot gained a greater understanding of their target populations and built trust and rapport with prospective WPC enrollees.

In providing care coordination, many WPC Pilots emphasized limited availability and/or accessibility of needed services, particularly housing and behavioral health as a barrier. Many Pilots also reported difficulty engaging appropriate partners in program implementation. Successes related to care coordination typically were a result of establishing meaningful relationships and formal contracts with partners, despite historical siloes and disengagement, to facilitate communication and effectively coordinate care.

WPC Pilots faced many unanticipated delays and challenges with data sharing, information technology, and reporting. Most frequently, WPC Pilots noted an inability to implement data sharing systems and/or integrate data as intended, as well as the presence of legal and cultural barriers to effectively share data for care coordination purposes. These challenges required WPC Pilots to devote extensive time and resources to ensuring enrollee privacy and generate buy-in from partners and frontline staff. Despite the initial challenges, all WPC Pilots reported progress in developing new software, platform, and/or repository.

Looking forward, WPC Pilots were beginning to evaluate the impact and associated cost savings of their programs. While Pilots were emphasizing anecdotal successes in their narrative reports, many expressed difficulties in assessing their Pilot objectively. This issue was complicated by lack of standard data from partners and providers and historical underutilization of services by certain target populations, which led to the inability to accurately show improvement in metrics when compared to baseline. During the remaining time left in the program, WPC Pilots planned to develop strategies to overcome these issues in order to provide convincing evidence of the impact of their Pilot.

With the Sector 1115 Waiver ending in December 2020, some WPC Pilots had begun formal sustainability planning. When discussing sustainability, WPC Pilots frequently mentioned uncertainty around waiver renewal and future waiver opportunities. They also noted that assessment of WPC impact on improvement amongst particularly difficult target populations

required longer than the five-year project timeline. Pilots were also concerned about the transition of responsibility amongst partners for care coordination after the waiver ends in 2020.

Appendix

Methods

Data Sources

Data used for this project included three mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services. In these reports, WPC Pilots were asked to report on program achievement/success/progress and program challenges/barriers and lessons learned in three major domains: care coordination; data and information sharing; and data reporting. WPC Pilots were also asked to report on biggest barriers to WPC success and on outcomes and sustainability of WPC. A complete overview of reporting requirements for these narrative reports are specified in Attachment GG Special Terms and Conditions. [4]

Qualitative Analysis

All narrative reports were reviewed for completeness and imported into the qualitative analysis software NVIVO 12.0. To facilitate analysis, all reports were organized by WPC pilot. An initial codebook was developed to correspond with sections outlined in the narrative reports; this codebook was subsequently refined to eliminate redundancies/repetition across sections of the narrative report and to reflect emergent themes in the data. All narrative reports were coded and reviewed by at least two members of the UCLA team. Four primary themes were identified: (1) identifying, engaging, and enrolling eligible beneficiaries; (2) care coordination; (3) data and information sharing; and (4) biggest barriers to WPC success. An additional round of coding was conducted to identify and quantify specific subthemes within the data. Only the most prevalent subthemes are included in this report.

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