



Whole Person Care (WPC) Program Updates

*Olmstead Advisory Committee
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Presentation Overview

1. WPC Program Overview

2. Summary of Applications

3. WPC Pilot Examples

4. Application Status Update

5. Questions/Open Discussion



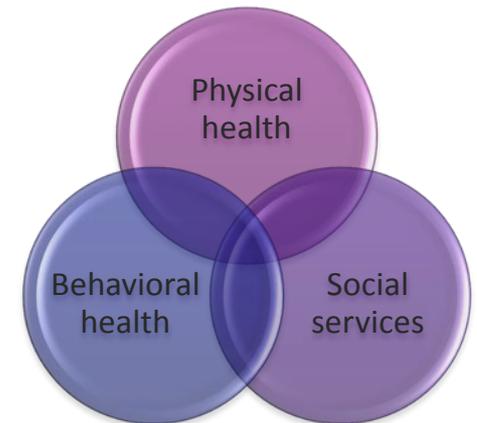
WPC Overview

Overarching goal:

- Coordination of health, behavioral health, and social services
- Comprehensive coordinated care for the beneficiary resulting in better health outcomes

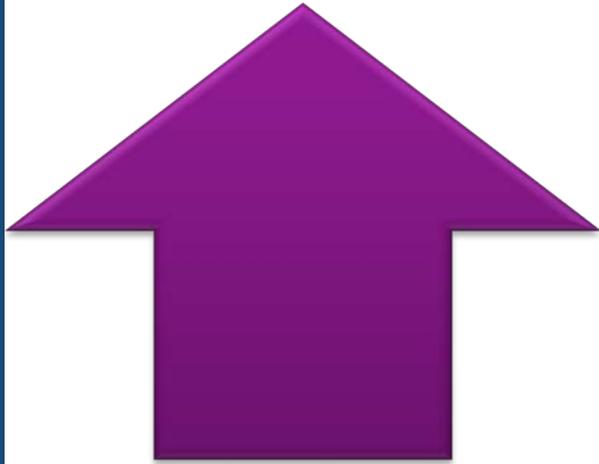
WPC Pilot entities collaboratively:

- Identify target populations
- Share data between systems
- Coordinate care real time
- Evaluate individual and population progress



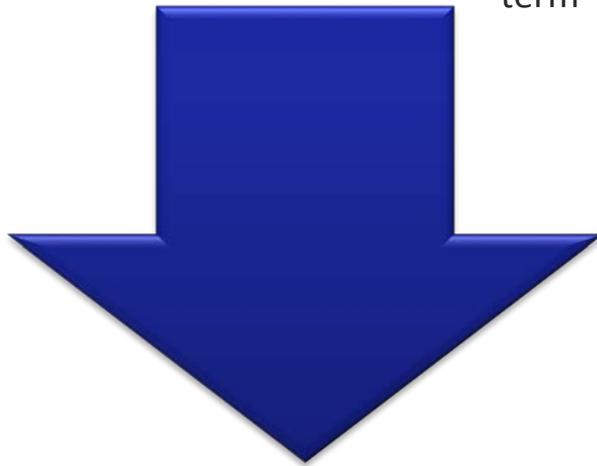


Goals and Strategies



Increase, improve, and achieve:

- Integration among county agencies, health plans, providers, and other participating entities
- Coordination and appropriate access to care
- Access to housing and supportive services
- Health outcomes for the WPC population
- Data collection and sharing among local entities
- Targeted quality and administrative improvement benchmarks
- Infrastructure that will ensure local collaboration over the long term



Reduce:

- Inappropriate emergency department and inpatient utilization



WPC by Numbers

5 year
program

\$1.5B total
federal funds

\$300M annual
available

2 application
rounds

18 applicants
for Round 1



WPC Program Structure



Administrative Infrastructure

Description

- Builds the programmatic supports necessary to plan, build and run the pilot

Examples

- Core program development and support
- Staffing
- IT infrastructure
- Program governance
- Training
- Ongoing data collection
- Marketing materials



Delivery Infrastructure

Description

- Supports the non-administrative infrastructure needed to implement the pilot

Examples

- Advanced medical home
- Mobile street team infrastructure
- Community paramedicine team
- Community resource database
- IT workgroup
- Care management tracking and reporting portal



Payment Mechanisms

PMPM Bundle

- One or more services and/or activities that would be delivered as a set value to a defined population
- Examples: Comprehensive complex care management, housing support services, mobile outreach and engagement bundle, long-term care diversion bundle

FFS Items

- Single per-encounter payments for a discrete service
- Examples: Mobile clinic visit, housing transition services, medical respite, transportation, sobering center, care coordination



Performance Measures

Objective

- To assess the success of the Pilot in achieving the WPC goals and strategies

Reporting requirements

- All WPC Pilots must report initial baseline and subsequent year data on universal and variant metrics as outlined in Attachment MM of the Special Terms & Conditions (STCs)



Performance Measures

Health Outcomes Universal Metrics

- Ambulatory Care - Emergency Department Visits
- Inpatient Utilization - General Hospital/Acute Care
- Follow-up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Health Outcomes Variant Metrics, as applicable

- 30 day All Cause Readmissions
- Decrease Jail Recidivism
- Overall Beneficiary Health
- Controlling Blood Pressure
- HbA1c Poor Control <8%
- Depression Remission at Twelve Months
- Adult Major Depression Disorder (MDD): Suicide Risk Assessment

Housing Variant Metrics, as applicable

- Percent of homeless who are permanently housed for greater than 6 months
- Percent of homeless receiving housing services in PY that were referred for housing services
- Percent of homeless referred for supportive housing who receive supportive housing

Pilot-identified Pay for Outcome metrics, other than required universal and variant metrics



Summary of Applications



First Round Applications

Counties with < 1,000 sq. mi. (7)

Alameda

Contra Costa

Napa

Orange

San Francisco

San Mateo

Solano

Counties between 1,001 – 3,000 sq. mi. (4)

Santa Clara

San Joaquin

Placer

Ventura

Counties between 3,001 – 5,000 sq. mi. (4)

Los Angeles

Monterey

San Diego

Shasta

Counties with > 5,000 sq. mi. (3)

Kern

Riverside

San Bernardino



Pilot Size

Larger:
Over 100,000

Los Angeles

Large:
Between
10,000 and
100,000

Alameda

Contra Costa

Riverside

Santa Clara

San Francisco

Medium:
Between 1,000
and 5,000

Kern

Orange

San Bernardino

San Diego

San Joaquin

San Mateo

Ventura

Small:
Between 250
and 800

Monterey

Napa

Placer

Shasta

Solano



Target Population

Target Population Criteria	# of Pilots that Selected this Target Population
1. High utilizers with repeated incidents of avoidable ED use, hospital admissions or nursing facility placement	15 Pilots
2. High utilizers with two or more chronic conditions	3 Pilots
3. Individuals with mental health and/or substance use disorder conditions	8 Pilots
4. Individuals who are homeless/at-risk for homelessness	14 Pilots
5. Individuals recently released from institutions (i.e., hospital, county jail, IMD, skilled nursing facility, etc.)	7 Pilots



Participating Entities

Required Partners

- (1) Medi-Cal managed care plan (MCP)
 - (1) Health Services Agency
 - (1) Specialty mental health plan
 - (1) Public Agency
 - (2) Community-Based Organizations (CBO)
 - (1) Public Housing Authority*
- *If housing interventions/services are selected

Identified Partners





Care Coordination Strategies

Navigation
infrastructure
(13 Pilots)

Standard
Assessment Tool
(9 Pilots)

Data sharing
systems
(9 Pilots)

Social
determinants
strategies
(7 Pilots)

Data-driven
algorithms
(4 Pilots)

Prioritization of
highest needs if on
a waiting list
(3 Pilots)



Data and Information Sharing

Expansion of
existing data
sharing framework
(18 Pilots)

Bi-directional data
sharing with MCPs
(18 Pilots)

Health Information
Exchange
(12 Pilots)

Patient population
software
(11 Pilots)

Data warehouse
(9 Pilots)

Query-based
real-time data
(7 Pilots)

Case management
software
(7 Pilots)

Real-time data
sharing
(6 Pilots)

New data sharing
systems
(3 Pilots)



Services and Interventions

Care Management
(15 Pilots)

Wellness and
Education
(9 Pilots)

Housing Services
(11 Pilots)

Flexible Housing
Pool
(17 Pilots)

Post-Incarceration
Services
(4 Pilots)

Mental Health
(6 Pilots)

Mobile Services
(4 Pilots)

Respite Services
(4 Pilots)

Sobering Centers
(4 Pilots)



WPC Pilot Examples



Services and Interventions/ PMPM Bundles

Care Management Bundle

- Ensures that all Medi-Cal eligible high utilizers across multiple systems (HUMS) and homeless individuals have access to comprehensive care coordination through a consistent county-wide complex care management system
- Two tiers – one for those not facing homelessness will have a 1:35 provider-to-patient ratio; the homeless will have a 1:30 ratio
- Administered by the Medi-Cal managed care plans and provided by a network of Community Based Care Management Entities (CB-CMEs)



Services and Interventions/ PMPM Bundles

Housing Bundle

- Enhanced housing transition service bundle which is provided by housing navigators who provide intensive care management, address housing barriers, housing search and application assistance and move-in support
- Housing and tenancy sustaining services bundle which provides residency retention services for patients in permanent supportive housing
- Skilled Nursing Facility Housing Transitions program provides SNF residents with intensive housing navigation services that complement the housing bundles



Services and Interventions/ FFS

FFS Items

- Sobering Center
- Housing education and legal assistance program to help low-income and high utilizing populations to maintain housing
- Substance Use Disorder (SUD) Diversion
- Behavioral health consultations with PCPs that are not included as Medi-Cal benefits
- Street outreach to link all unsheltered chronically homeless individuals to care
- Community Living Facilities Quality Improvement to improve the quality of low income housing facilities
- Client Move-In Fund for Housing Navigators to assist patients with move-in expenses



Data Sharing Approach

Streamlined data sharing across multiple systems

- Continuity of Care document to allow physicians to send electronic medical information to other providers
- Data Sharing Workgroup
- Agreed-upon data elements using the Common Meaningful Use Data Set as a base format
- Dedicated server and data repository supported by reporting tools
- Care management applications will be used by care managers and other end users



Services and Interventions/ SNF Services

Care Management Bundles

- Offers (3) tiered care management packages depending on the length of care required and need intensity
- Includes intensive care coordination, transportation assistance, peer counseling, and patient medication counseling
- Rehabilitation and Peer Support bundle includes housing supports, employment assistance, and peer support

Integrated Medical/Psychiatric Skilled Nursing Facility (SNF) Services

- Dedicated unit to address concurrent medical/psychiatric needs that result in avoidable stays in acute environments
- Builds upon the existing services that provide either medical or psychiatric services by creating an incentive to add staff to provide both services concurrently



Application Status Update



Application Status Update

Approved

14 counties approved

Pending

4 counties still going through the review process



Second Round of Applications

Requirements

- The general requirements will remain the same as the first round.

Who can apply

- New applicants
- Applicants may amend applications already approved in the first round to add new target populations and/or services and interventions.

Forthcoming Guidance

- DHCS plans to update the application based upon lessons learned from the first round.
- Additional guidance will be provided prior to the release of the second round of applications.

Timeline

- Revised application will be released in January 2017
- Applications are due March 1, 2017



Resources

Visit the
Whole Person
Care webpage:

<http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>

Submit
questions/sign
up for the
listserv:

1115WholePersonCare@dhcs.ca.gov



Questions and Discussion