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A Snapshot of California's Whole Person Care Pilot Program: Implementation Strategies and Enrollees

Nadereh Pourat, Brenna O'Masta, Leigh Ann Haley, and Emmeline Chuang

"The Whole Person Care Pilot program coordinates medical, behavioral, and social services to improve the health and well-being of Medi-Cal beneficiaries with complex needs."

SUMMARY: The Whole Person Care (WPC) Pilot program implemented under California's Section 1115 Medicaid Waiver, "Medi-Cal 2020," coordinates medical, behavioral, and social services to improve the health and well-being of Medi-Cal beneficiaries with complex needs. In this policy brief, we analyze data from the interim statewide evaluation of WPC to present a snapshot of the 25 participating pilots, based on key implementation strategies and enrollee characteristics. The data can be used by organizations that are developing population health management programs for high-need, high-risk Medi-Cal beneficiaries under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, as well as by other programs providing care to low-income patients.

A small proportion of the insured population is responsible for a relatively large proportion of the health services used in the United States.[1] Many of these individuals have complex medical, behavioral health, and social needs that require an integrated approach to care.[2] In 2016, the California Department of Health Care Services (DHCS) began a demonstration program called Whole Person Care (WPC) to promote the integrated delivery of care for Medi-Cal beneficiaries who use acute and costly services in multiple care areas. Under WPC, eligible beneficiaries receive care coordination and other services not traditionally covered by Medi-Cal to address medical, behavioral health, and social needs, with the aim of improving their health outcomes and overall well-being.

In 2017, 25 WPC pilots in 26 counties began enrolling eligible Medi-Cal beneficiaries. Pilots had flexibility in the specific target populations served and in how WPC was implemented.[3] WPC was originally scheduled to end in December 2020 but was extended for a year due to the COVID-19 pandemic.

Some of the services provided under WPC will be incorporated into CalAIM, a multiyear initiative planned by DHCS that is designed to use WPC approaches to improve beneficiaries' health outcomes. Under CalAIM, Medi-Cal managed care plans are expected to provide Enhanced Care Management (ECM) and In Lieu of Services (ILOS) through contracts with community-based providers, including organizations participating in WPC.[4] CalAIM is expected to begin implementation in January 2022. This policy brief provides a snapshot of each pilot's implementation strategies and enrollee characteristics to inform CalAIM transition planning. Data are drawn from the statewide evaluation of WPC conducted by the UCLA Center for Health Policy Research.[5, 6]

"The data indicate the importance of tailoring future efforts to the unique needs of various subgroups of Medi-Cal enrollees."

WPC Program Implementation Strategies

Exhibit 1 provides insight into similarities and differences by county across pilots in the target populations served, strategies used to identify and enroll eligible beneficiaries, care coordination approaches, other WPC services offered, and engagement of social service providers as partners. For example, data show that 16 pilots provided services to more than one target population, and 16 used street- or shelter-based outreach to identify eligible enrollees. Thirteen pilots used a single dedicated care coordinator to follow enrollees across all WPC-participating care settings, and 17 used co-located staff from different service sectors to facilitate access to care. Care coordinators' caseloads varied significantly across pilots (from 10 to 300), reflecting differing levels of enrollee need and intensity of services provided. Highlighting the importance of housing support to enrollees, 12 pilots offered tenancy support, landlord incentives, and funds to support housing placement. Many provided medical respite (18) and sobering centers (14).

WPC Enrollee Characteristics

Exhibit 2 provides insight into the WPC enrollee profile by county, including enrollment information, the demographics and health status of enrollees, and the utilization of services by these individuals prior to WPC enrollment. Pilots differed in multiple elements, such as the number of enrollees served (from fewer than 300 to more than 10,000); average length of enrollment (3–17 months); inclusion of adults 65 years of age or older (1%–22%); individuals experiencing homelessness (4%–100%); those affected by mental health conditions (30%–87%) or substance use disorders (12%–67%); and those ever involved with the justice system during enrollment (0%–100%). Data showed considerable variation across pilots in the average use of services pre-WPC (per enrollee, per year) for outpatient services (7.4–50.4), ED visits (1–5.8), and hospitalization rates (0.3–2.2).

WPC Pilot Profiles

Collectively, these data demonstrate how individual pilots tailored their approaches to address community-specific needs. For example, Los Angeles County's WPC pilot focused on all six target populations and used multiple programs and forms of outreach to identify and enroll eligible beneficiaries. A diverse care coordination team that included peer staff helped link enrollees to a medical home and services such as housing and medical respite. In another example, Riverside County's WPC pilot focused on serving the justice-involved population; co-located WPC enrollment staff with probation staff to enroll individuals in jails and prisons prior to release; and used a single dedicated care coordinator (typically, a registered nurse) to connect enrollees to a medical home and services, including employment assistance.

Implications for Transition to CalAIM

This snapshot is intended to inform efforts to transition the WPC program into ECM and ILOS components of CalAIM. Heterogeneity across pilots in program implementation and enrollee characteristics highlights the importance of tailoring future efforts to the unique needs of various subgroups of Medi-Cal enrollees with high utilization of services. In some counties, a narrower focus on specific target populations or smaller enrollment indicate that additional work is needed to expand enrollment to everyone with high levels of need and service use. The data also reflect the level of effort necessary to establish a specific infrastructure for effectively serving identified target populations.

Exhibit 1 WPC Program Implementation Elements by Pilots as of July 2020

	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa (SCWPCC)	Mendocino	Monterey	Napa	Orange	Placer	Riverside
Primary target population													
1. High utilizer	1	1	1		1	1	1					1	
2. Homeless	2		2		2	2			2	2	2	2	
3. At risk of homelessness			3		3	3				3		3	
4. Chronic physical conditions				4	4							4	
5. Severe mental illness/substance use disorders (SMI/SUD)				5	5		5	5			5	5	
6. Justice-involved			6		6							6	6
Enrollment Strategies													
Identification approach													
1. Street- or shelter-based outreach			1	1	1	1			1		1	1	
2. Health care facility outreach		2	2	2	2	2		2	2	–	2	2	
3. Referrals		3	3	3	3	3	3	3	3		3	3	3
4. Administrative data (e.g., health plan eligibility lists)	4		4			4	4	4	4				
5. Predictive modeling based on program criteria		5										5	
Enrollment approach													
1. At health care facilities			1	1	1	1	1	1			1	1	1
2. Warm handoff at co-located organization		2	2	2	2	2	2	2	2	–	2	2	2
3. On street, at shelter, or other community-based location			3	3	3	3	3	3	3		3	3	
4. By telephone			4	4	4			4	4			4	
5. Auto-enrollment and opt out	5	5			5								
Care Coordination Approach													
Organization of care coordinators (CC)													
1. Single CC	1	1	1	1			1	1		–		1	1
2. Multiple CCs					2	2			2		2		
Average CC caseload (by tier)	15	(25, 80, 300)	–	(30, 75)	25	(17, 30)	10	19	43	40	35	20	50
Selected types of staff included in care coordination team													
1. CHW or staff with lived experience	1	1		1	1	1	1	1		–	1	1	1
2. Licensed social worker or psychologist	2	2	2		2	2	2	2	2		2	2	2
3. Physician or nurse practitioner	3	3	3		3	3	3	3			3		3
Type of co-located staff to facilitate access to services and resources													
1. Medical	1	1	1	1	1	1	1		1		1		1
2. Mental health	2		2	2	2	2	2		2	–	2		2
3. Housing						3		3			3	3	
4. Non-housing social services		4	4	4	4	4	4	4			4	4	
5. Substance abuse			5	5		5					5		5
CCs have real-time access to at least some of the following data:													
1. Medical	1	1	1	1	1	1	No	1	No	–	1	1	1
2. Behavioral health	2	2		2		2						2	2
3. Social services	3	3	3	3		3		3					3
Care coordinators can access needs assessment, comprehensive care plan, and referrals in the same system		✔	✔	✔	✔	✔	✔	✔	✔	–	✔		
Selected WPC Services Offered													
Housing-related services													
1. Housing navigation, tenancy support	1	1	1	1	1	1	1	1	1	–	1	1	1
2. Landlord incentives	2		2		2	2	2		2		2	2	2
3. Funds (e.g., security deposit, utilities)	3	3	3		3	3	3	3	3		3	3	
Selected other services													
1. Employment assistance		1	1	1	1	1	1	1	1	–	1	1	1
2. Sobering center	2			2	2			2	2				2
3. Recuperative care (medical respite)	3		3		3	3	3	3			3	3	
Partnership Characteristics													
Total number of organizations participating in WPC pilot	42	12	15	8	50	39	11	8	17	12	34	24	14
Types of partners with highest engagement with WPC administration													
1. Housing	1		1		1	1		None	1	1	1	1	1
2. Justice	2	2	2	2	2	2	2		2	2		2	2
3. Other social services	3	3	3	3	3	3	3		3	3	3	3	3

Note: Unavailable data are indicated by a dash (–).

(Exhibit 1 continues on next page)

WPC Program Implementation Elements by Pilots as of July 2020

Exhibit 1

	Sacramento	San Benito (SCWPCC)	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura
Primary target population													
1. High utilizer	1	1	1	1		1	1	1		1	1		1
2. Homeless	2	2		2	2	2						2	
3. At risk of homelessness		3		3		3						3	
4. Chronic physical conditions									4				
5. Severe mental illness/substance use disorders (SMI/SUD)						5			5		5	5	
6. Justice-involved													
Enrollment Strategies													
Identification approach													
1. Street- or shelter-based outreach	1	1		1	1	1	1			1		1	1
2. Health care facility outreach	2	2		2	2	2	2	2		2	2		2
3. Referrals	3	3		3	3	3	3	3	3	3	3	3	3
4. Administrative data (e.g., health plan eligibility lists)	4	4	4		4	4	4	4	4		4	4	4
5. Predictive modeling based on program criteria			5		5			5					5
Enrollment approach													
1. At health care facilities	1	1	1	1		1	1	1	1	1	1	1	1
2. Warm handoff at co-located organization	2	2	2	2		2	2	2		2	2	2	
3. On street, at shelter, or other community-based location		3	3	3		3	3	3	3	3	3	3	3
4. By telephone				4			4	4	4			4	4
5. Auto-enrollment and opt out					5								
Care Coordination Approach													
Organization of care coordinators (CC)													
1. Single CC		1				1		1	1		1	–	
2. Multiple CCs	2		2	2	2		2			2			2
Average CC caseload (overall and by tier)	(55, 75)	13	55	(5, 13)	176	75	(6, 31)	30	30	23	35	20	(50, 100)
Selected types of staff included in care coordination team													
1. CHW or staff with lived experience	1	None	1	1	1	1	1	1	1		1	1	1
2. Licensed social worker or psychologist	2			2	2	2	2	2	2	2	2	2	2
3. Physician or nurse practitioner	3			3	3	3	3	3	3			3	3
Type of co-located staff to facilitate access to services and resources													
1. Medical	1				1			1					
2. Mental health		2	None	None		–	None		None	None	None	None	
3. Housing	3	3			3								3
4. Non-housing social services		4			4			4					4
5. Substance abuse		5											
CCs have real-time access to at least some of the following data:													
1. Medical	1	1	No	1	No	1	1	No	1	No	2	–	1
2. Behavioral health	2	2					2						2
3. Social services	3	3		3		3	3				3		3
Care coordinators can access needs assessment, comprehensive care plan, and referrals in the same system	✔	✔	✔	✔	✔	✔					✔	–	✔
Selected WPC Services Offered													
Housing-related services													
1. Housing navigation, tenancy support	1	1	1	1	1	1		1	1	1	1	–	1
2. Landlord incentives	2	2						2					
3. Funds (e.g., security deposit, utilities)	3	3		3	3		3	3	3	3			
Selected other services													
1. Employment assistance	1	1		1				1		1	1	1	1
2. Sobering center		2	2		2	2	2	2		2		2	
3. Recuperative care (medical respite)	3	3	3	3	3	3		3	3		3		3
Partnership Characteristics													
Total number of organizations participating in WPC pilot	31	10	9	20	9	25	8	43	18	15	11	16	46
Types of partners with highest engagement with WPC administration													
1. Housing	1	1			1	1	1	1	None	1		1	1
2. Justice	2		2	2		2							2
3. Other social services	3	3	3	3	3			3		3	3	3	3

Note: Unavailable data are indicated by a dash (–).

Exhibit 2 WPC Enrollment Profile by Pilots for the First Two Program Years, 2017–2018

	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa (SCWPCC)	Mendocino	Monterey	Napa	Orange	Placer	Riverside
Primary target population 1. High utilizer 2. Homeless 3. At risk of homelessness 4. Chronic physical conditions 5. Severe mental illness/substance use disorders (SMI/SUD) 6. Justice-involved	1 2	1	1 2 3 6	4 5	1 2 3 4 5 6	1 2 3	1 5	5	2	2 3	2 5	1 2 3 4 5 6	6
Enrollment Characteristics													
Total enrollment 1. Up to 300 2. 301–1,000 3. 1,001–10,000 4. >10,000	3	4	2	1	4	2	1	1	1	1	3	1	3
Ever disenrolled (%)	10	56	4	49	66	2	–	15	44	38	57	63	15
Mean length of overall enrollment, in months	7	13	5	7	11	3	5	9	14	9	11	14	6
Enrollee Demographics													
Age 0–20 at enrollment (%)	3	5	2	–	1	–	0	–	0	–	3	0	3
Age 45–64 at enrollment (%)	48	38	41	33	48	53	63	50	62	48	50	63	21
Age 65 years or older at enrollment (%)	6	15	4	–	5	12	–	10	14	5	7	10	1
Male (%)	56	40	53	55	62	63	52	50	48	61	59	58	76
White (%)	22	27	34	37	21	61	85	76	34	69	48	75	33
African American or Black (%)	44	22	13	11	35	16	0	–	–	–	6	–	15
Latinx (%)	12	24	41	43	28	10	–	7	34	19	25	7	43
Ever homeless during enrollment (%)	19	4	31	15	51	64	–	46	95	100	100	97	27
Ever justice-involved during enrollment (%)	–	–	42	30	2	0	–	48	–	0	0	20	100
Enrollee Health Status at Enrollment (Light Orange = Lowest %; Dark Orange = Highest %)													
Any chronic physical health condition (%)	73	59	53	64	69	69	82	85	89	75	61	72	37
Hypertension (%)	24	21	22	15	20	20	41	19	40	21	18	21	5
Diabetes (%)	11	15	12	13	12	8	–	12	30	11	9	12	2
Any chronic mental health condition (%)	65	33	30	54	58	62	67	80	71	70	49	66	33
Any substance use disorder (%)	38	12	15	22	24	37	–	48	52	50	31	44	23
Pre-WPC Utilization per Enrollee per Year (Light Orange = Lowest Quartile; Dark Orange = Highest Quartile)													
Number of outpatient services	22	10	20	15	20	19	20	33	27	16	11	13	7
Number of outpatient mental health services	11	3	3	5	11	6	6	19	8	4	4	4	3
Number of outpatient substance use disorder services	4	1	6	2	3	2	1	2	3	4	2	2	2
Number of emergency department visits	2.3	1.0	1.5	2.0	2.3	2.0	3.6	2.7	5.0	2.2	2.3	2.6	1.3
Number of hospitalizations	1.0	0.5	0.3	0.3	1.0	0.6	0.5	0.3	1.2	0.4	0.6	0.6	0.3

Notes: Unavailable or sparse data are indicated by a dash (–).

Health status conditions are based on CMS' Chronic Condition Warehouse condition categories.

Utilization is measured during two years pre-WPC enrollment.

Outpatient services include any service not provided in an inpatient setting, at the emergency department, or through long-term care.

(Exhibit 2 continues on next page)

WPC Enrollment Profile by Pilots for the First Two Program Years, 2017–2018

Exhibit 2

	Sacramento	San Benito (SCWPCC)	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura
Primary target population 1. High utilizer 2. Homeless 3. At risk of homelessness 4. Chronic physical conditions 5. Severe mental illness/substance use disorders (SMI/SUD) 6. Justice-involved	1 2	1 2 3	1	1 2 3	2	1 2 3 5	1	1	 4 5	1	1 5	 2 3 5	1
Enrollment Characteristics													
Total enrollment 1. Up to 300 2. 301–1,000 3. 1,001–10,000 4. >10,000	2	1	2	1	4	2	3	3	2	1	1	2	3
Ever disenrolled (%)	31	53	28	5	43	13	40	17	10	74	43	38	13
Mean length of overall enrollment, in months	8	5	11	5	14	7	16	17	13	12	13	5	11
Enrollee Demographics													
Age 0–20 at enrollment (%)	–	0	8	0	0	0	1	1	–	–	0	4	1
Age 45–64 at enrollment (%)	61	74	44	78	50	50	44	59	49	67	58	42	57
Age 65 years or older at enrollment (%)	8	–	6	–	8	4	22	8	22	–	9	11	3
Male (%)	57	52	45	58	72	52	52	49	60	50	48	50	46
White (%)	38	56	22	50	29	40	34	29	57	77	32	58	42
African American or Black (%)	31	0	18	15	31	18	7	8	–	–	35	5	4
Latinx (%)	9	41	46	11	11	26	27	34	11	5	10	12	38
Ever homeless during enrollment (%)	98	97	4	61	100	47	34	41	54	98	50	–	59
Ever justice-involved during enrollment (%)	0	61	0	9	–	14	0	0	15	0	–	0	0
Enrollee Health Status at Enrollment (Light Orange = Lowest %; Dark Orange = Highest %)													
Any chronic physical health condition (%)	61	82	86	85	64	74	85	81	89	89	91	74	82
Hypertension (%)	24	–	31	39	15	28	38	34	27	29	50	20	31
Diabetes (%)	14	–	21	25	6	14	23	25	14	19	28	12	19
Any chronic mental health condition (%)	49	85	71	70	57	63	62	53	87	80	65	70	67
Any substance use disorder (%)	33	67	24	51	42	38	31	28	35	53	46	41	43
Pre-WPC Utilization per Enrollee per Year (Light Orange = Lowest Quartile; Dark Orange = Highest Quartile)													
Number of outpatient services	19	16	24	31	23	26	26	22	50	24	27	22	26
Number of outpatient mental health services	4	5	10	8	8	9	10	5	29	6	4	9	7
Number of outpatient substance use disorder services	8	3	5	4	10	4	4	2	9	2	2	4	3
Number of emergency department visits	2.9	4.5	2.9	5.8	3.2	5.0	3.6	2.6	2.8	4.0	5.1	2.4	3.3
Number of hospitalizations	0.7	1.0	1.7	1.9	0.8	0.7	2.2	0.9	0.8	0.7	1.5	1.2	0.8

Notes: Unavailable or sparse data are indicated by a dash (–).

Health status conditions are based on CMS' Chronic Condition Warehouse condition categories.

Utilization is measured during two years pre-WPC enrollment.

Outpatient services include any service not provided in an inpatient setting, at the emergency department, or through long-term care.

10960 Wilshire Blvd., Suite 1550
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Editor-in-Chief: Ninez A. Ponce, PhD

Phone: 310-794-0909
Fax: 310-794-2686
Email: chpr@ucla.edu
healthpolicy.ucla.edu

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Author Information

Nadereh Pourat, PhD, is associate director of the UCLA Center for Health Policy Research and director of the Center's Health Economics and Evaluation Research Program. Brenna O'Masta, MPH, and Leigh Ann Haley, MPP, are project managers and research analysts at the UCLA Center for Health Policy Research. Emmeline Chuang, PhD, is director of the Mack Center on Nonprofit and Public Sector Management in the Human Services at the University of California, Berkeley, and an associate professor in UC Berkeley's School of Social Welfare.

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Data and Methodology

Data in Exhibit 1 are from a questionnaire administered to all pilots in June–July 2020. Designation of lowest and highest percentages or utilization in Exhibit 2 are identified by examining the distribution of each indicator across pilots and selecting the lowest and highest 25% or quartile.

For more detailed methods, please refer to the UCLA Center for Health Policy Research publication *Interim Evaluation of California's Whole Person Care (WPC) Program* (see Endnote 6).

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Endnotes

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3 California Department of Health Care Services. 2018. Attachment GG: Whole Person Care Reporting and Evaluation Attachment. *California Medi-Cal 2020 Demonstration, Centers for Medicare and Medicaid Services Special Terms and Conditions.* Sacramento, Calif.: California Department of Health Care Services. *https://www.dhcs.ca.gov/provgovpart/Documents/CA-Medi-Cal-2020-STCs-CMS-TC-11-19-19-NoExpWaiver.pdf*

4 ECM includes care coordination and comprehensive care management services to address clinical, behavioral, and social needs of high-cost and/or high-need Medi-Cal beneficiaries. ILOS services (e.g., recuperative care, sobering center stays) can substitute medical services (e.g., emergency department visits) covered under Medi-Cal.

5 Chuang E, O'Masta B, Albertson E, Haley LA, Lu C, Pourat N. 2019. *Whole Person Care Improves Care Coordination for Many Californians*. Los Angeles, Calif.: UCLA Center for Health Policy Research.

6 Pourat N, Chuang E, Chen X, O'Masta B, Haley LA, Lu C, Huynh MP, Albertson E, Huerta DM. 2019. *Interim Evaluation of California's Whole Person Care (WPC) Program*. Los Angeles, Calif.: UCLA Center for Health Policy Research.