Whole Person Care- Los Angeles Policy Brief

May 2020

Whole Person Care Transitions of Care Program Reduces Emergency Department and Inpatient Admissions for Medically High-Risk Individuals in Los Angeles County

SUMMARY: The Los Angeles County Department of Health Services Whole Person Care program optimizes care for medically high-risk patients while reducing the utilization of costly acute care through a safety-net program that supports patients' transition from hospital to home. As part of this Transitions of Care Program, Whole Person Care community health workers engage patients in the hospital and link them to primary care, behavioral health, and social services through a 30-day intensive care management system. Since the start of the program in 2017, there has been a 19% reduction in emergency department visits, a 29% reduction in inpatient admissions, and a 12% increase in primary care use.[1]

PROBLEM: The High Financial and Societal Cost of Readmissions

From 2006 to 2016, emergency department (ED) use drastically increased by 44% throughout California.[2] In Los Angeles, there were 364 emergency department (ED) visits per 1,000 population in 2016, and approximately 55 per 1,000 visits resulted in hospital admissions.[2] Medically high-risk patients with complex health conditions and limited socioeconomic resources are especially vulnerable to admission and readmission to the ED and hospital, contributing to a high societal cost and health disparities. Coordinating care for patients with myriad needs strains health care systems; a typical high-risk patient will require care from a median of seven physicians in a year.[3]

SOLUTION: The Transitions of Care (TOC) Program

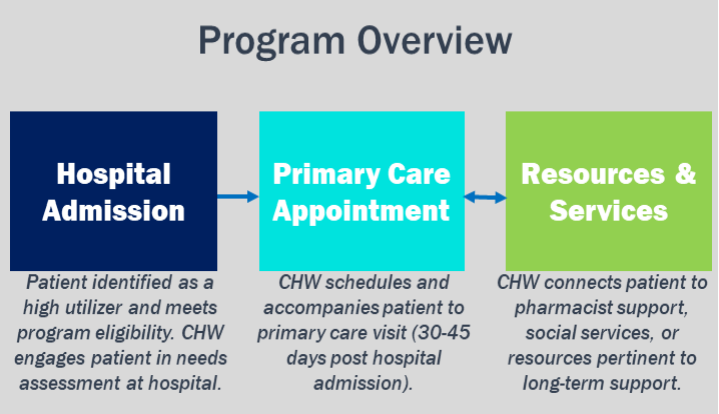
To optimize care for medically high-risk patients while reducing ED and hospital readmissions, the Los Angeles County Department of Health Services Whole Person Care (WPC) program administers the 30-day Transitions of Care (TOC) Program. WPC TOC works to comprehensively address the physical and behavioral health issues and health-related social needs of complex patients. WPC TOC began in May 2017 as a part of Los Angeles County's Whole Person Care (WPC) Pilot, a five-year program within the 1115 Medicaid waiver that helps ensure that the most vulnerable Medi-Cal beneficiaries have the resources and support they need to thrive. WPC TOC is implemented at Olive View-UCLA Medical Center, LAC-USC Medical Center, White Memorial Medical Center, and Harbor-UCLA Medical Center.

Program Goals

The WPC TOC Program uses a community health worker (CHW) model to engage medically high-risk patients early in primary and specialty care. WPC CHWs link patients to primary care with extended clinical support (i.e., pharmacists), behavioral health providers, and additional linkage to community-based organizations (CBOs) for housing, employment, and other social services. By providing patient-centered care and bridging clinical teams and community-based organizations, TOC brings the health delivery system together for its patients.

Program Services

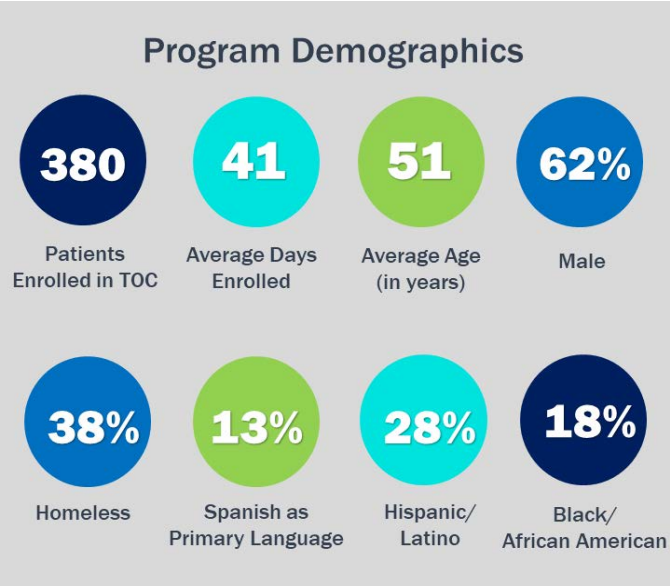
WPC CHWs, social workers, pharmacists, and CBOs work together to bridge care from the inpatient hospital teams to the outpatient primary care teams by providing culturally competent, community-based, and intensive services to hospitalized patients for 30 to 45 days after discharge. CHWs bridge care through home visits and accompaniment to appointments, providing social support, medical navigation support, and linkage to appropriate medical, mental health, and social services within the community. CHWs were hired to be reflective of the community served, including through lived experience. CHWs are supervised by social workers, contributing to the unique focus of the program on social services in addition to medical needs.



Program Eligibility

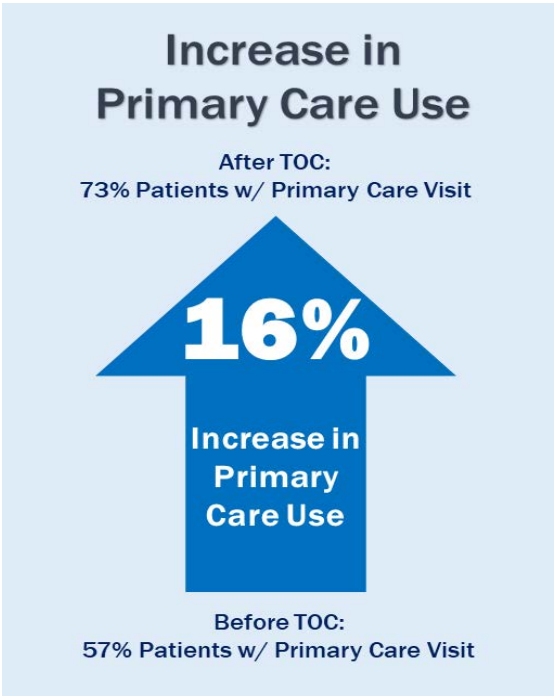
The WPC TOC Program targets medically high-risk adult patients with multiple hospital admissions. TOC patients are particularly vulnerable and often face challenges including chronic conditions, homelessness, substance use disorder, and mental health disorders. Patients must live in Los Angeles County, be on or eligible for full scope Medi-Cal, and not be transferred to a skilled nursing facility or recuperative care after discharge. Detailed eligibility criteria are on page four.

[1] Due to limited data availability, a full cost-benefit analysis was not completed. However, the reduction in high-cost utilization implies an overall cost-reduction.
[2] California Health Care Foundation. California Emergency Departments: Use Grows as Coverage Expands. California Health Care Almanac. 2018.
[3] Pham HH, Schrag D, O'Malley AS, Wu B, Bach PB. Care patterns in Medicare and their implications for pay for performance. The New England Journal of Medicine. 2007; 356(11):1130-1139. doi:10.1056/NEJMsa063979

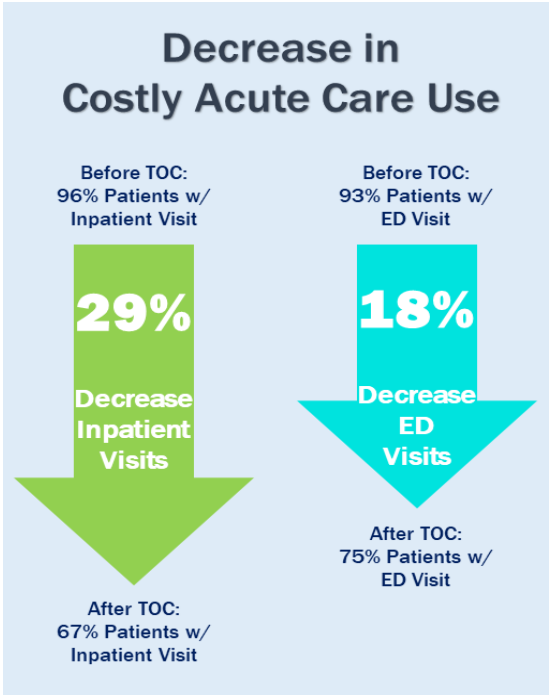


OUTCOMES: Reduction in High-Cost Care and Increase in Primary Care

From 2017 to 2018, there were 785 patients enrolled in the WPC TOC Program. WPC TOC achieved its goal of increasing primary care use. In the year after WPC TOC enrollment, compared to the year before enrollment, primary care visits following discharge increased. Over a third of WPC TOC patients had a primary care visit within 30 days of discharge from the hospital.



WPC TOC also achieved its goal of reducing utilization of costly acute care. In the year after WPC TOC enrollment, compared to the year before enrollment, WPC TOC patients had lower ED visits and inpatient admissions. Less than a third of WPC TOC patients had a hospital readmission within 30 days of their last admission.



Program Strengths

- *Community Health Workers*: Engagement of the most vulnerable patients was facilitated by trained CHWs who have shared lived experience with patients, thus facilitating a relatable workforce. CHWs serve as strong advocates, help to build trust with the medical system, and support navigation of complex health and social systems, while also trying to foster patient independence.

- *Social-Service Driven Workforce:* The CHWs are supervised by social workers, and together this team is uniquely positioned to address health-related social needs that may impact a patient's ability to thrive.

- *Community-Based CHW Support:* WPC teams provide field-based, home, or street visits and accompany the patient to important appointments after hospitalization. By being based in the community, patient engagement occurs beyond the walls of clinics and hospitals and helps 1) identify unmet needs in a patient's living situation, 2) reduce barriers to receiving care, and 3) make practical suggestions to reinforce health education and coaching.

Perspective from a TOC Community Health Worker

"At the end of that [PCP visit], the patient is sitting there and they're going, "You know, this was my first doctor's appointment." And you see the lightbulb click… We've just planted a seed that their health is important… it's really successful just when they can take away a piece of information from that appointment that allows them to modify something in their life to improve it."

Program Challenges

- *Health Care Team Engagement:* WPC TOC CHWs engage with busy hospital inpatient, ED, primary care, and behavioral health teams. The health care system is difficult to navigate, even for trained CHWS. WPC TOC team members work continuously with clinical teams to maximize care coordination and the potential impact on patients. In particular, close alignment with hospital teams is key to engaging medically high-risk patients during their hospitalization, a time of great need.

- *Program Length*: The WPC TOC Program was designed to be a 30-day program from hospital discharge to primary care follow-up after hospitalization. In practice, program enrollment, goal setting, appointment scheduling, and primary care accompaniment led to an average of 41 days in the program.

- *Social Factors*: Basic needs, including a lack of affordable housing and shelter access in Los Angeles, are challenges to comprehensively addressing patient needs and goals. Housing is frequently a patient need, but spaces in shelters and permanent supportive housing are limited.

- *Eligibility*: Medi-Cal restrictions limit who can participate in the program.

Policy Recommendations

- *Transitions of Care Programs Reduce High-Cost Care*: Hospital-to-home transitions of care approaches must be a central component of the Enhanced Care Management (ECM) Program for every target population in future health care reform iterations, including within Medi-Cal Healthier California for All.

- *Community Health Workers Provide Multiple Benefits to TOC Programs*: CHWs are evidence-based health team members who engage patients and help reduce readmission following discharge from the hospital. Trained, supervised CHWs should be the central care management team members on transitions of care teams.

- *Early In-Hospital Engagement with High-Risk Patients Helps to Link to Appropriate Services:* Early engagement in the hospital is critical to plan for transitions of care with high-risk patients. ECM teams should engage with patients in the hospital setting when feasible (e.g. in high-volume hospitals). Workflows should be developed to ensure engagement prior to discharge from the hospital.

- *High-Volume Medicaid Hospitals are in Particular Need of TOC Programming:* Health plans should consider supporting hospital-based TOC teams in all high-volume Medicaid hospitals. These teams could work closely to ensure warm hand-offs to multiple community-based ECM providers and primary care teams, maximizing the opportunity to engage beneficiaries and reduce ED visits and readmissions following hospital discharge.

Patient Success Story

"Robert," a 47-year-old homeless man, was referred to the Whole Person Care Transitions of Care Program by a hospital where he was being treated for acute and highly infectious health issues. Sheryl, Robert's CHW, learned that he also suffered from mental illness. Robert had a history of psychosis that was complicated by homelessness and substance use.

Once discharged from the hospital, Sheryl and Robert worked on setting goals to empower him to lead a healthy and independent lifestyle. Sheryl helped Robert find a primary care provider and schedule follow-up appointments. She also linked him to the Countywide Benefits Entitlement Services Team Program, which helped Robert obtain Supplemental Security Income and Social Security Disability Insurance benefits.

To help Robert address his mental health disorder, Sheryl referred him to a mental health center. At the center, Robert accessed treatment and dual diagnosis support groups. A psychiatrist helped Robert with his psychiatric medications. Robert also received medication-assisted treatment for his substance use disorder. Sheryl accompanied Robert to many of these appointments to provide support and reinforcement.

To relieve a stressful housing situation, Sheryl helped Robert apply for General Relief Housing, and he soon moved out into a sober living home. Today, Robert consistently attends Narcotics Anonymous meetings, receives support from a sponsor, and is proud of attaining his first year of sobriety. He is working well with his new primary care provider and is learning how to manage his health day by day.

Authors

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Data and Methodology

Demographic data for patients enrolled from May 2017 to March 2018 are pulled from CHAMP, the database used to document demographic information on WPC TOC patients and their interactions with CHWs. Outcomes for patients with any ED, inpatient, or primary care visit from May 2016 to March 2019 are preliminary. Post-discharge primary care use and hospital readmission rates are unadjusted. Data are pulled from enrollment and utilization files from Los Angeles County Department of Health Services, LA Care, and Health Net.

Detailed Eligibility Criteria

Individuals discharged from an acute care hospital with three or more inpatient admissions within the past year

OR

Individuals with two or more inpatient admissions within the past year AND at least one of the following:

- Four or more ED visits in the past six months;
- Initiated insulin or anticoagulation during the enrolling hospital admission;
- Are taking more than six medications daily;
- Substance use disorder;
- Mental health disorder;
- Homeless or at risk of homelessness; and/or
- Justice involvement within the past six months