Whole Person Care - Cruz to Health
Lessons Learned: Care Coordination

Introduction

The Whole Person Care - Cruz to Health pilot program (WPC-C2H) launched in Santa Cruz County in 2017. Led by the Santa Cruz County Health Services Agency, the pilot incorporates both direct services to the specific target populations and initiatives to develop and test systems to improve care coordination across the community. The whole person care model incorporates a system of collaborative leadership and systematic coordination to share data between providers of care, coordinate care in real time, and evaluate individual and population progress. The primary goal is to utilize evidence-based interventions to improve care management for the increased health and wellbeing of Medi-Cal beneficiaries with complex needs such as co-occurring chronic conditions, and history of high utilization of multiple systems. The engagement of a wide spectrum of social services providers with medical care is essential to the model, and a list of organizations participating in the WPC-C2H pilot are listed in Appendix A.

A key element of the Santa Cruz County WPC-C2H pilot is coordinating care among multiple service providers to support the success of clients with complex needs. This report will focus specifically on why and how Care Coordination impacts health status and outcomes, what has been accomplished in improving Care Coordination, and the system changes that are being tested to support lasting change. In the process of developing the findings of this report seven WPC-C2H staff and other key stakeholders were interviewed.

Complex Needs and Care Coordination

WPC-C2H was established with the specific goal to improve the health and wellbeing of the county's most vulnerable residents. 513 clients with complex needs have been served by the program between July 2017 and March 2020. These individuals typically experience several of the following: homeless for approximately five years, high emergency department utilization, two or more chronic medical conditions, non-compliance, past traumas, substance use diagnosis, history with criminal justice, person of color experiencing discrimination, and unreliable transportation.

Due to the traditionally fragmented nature of health care provision in the U.S., clients with complex needs struggle to manage medical, behavioral health, and social services to receive the holistic care they require. Care Coordination and integrated services have been shown to improve the client experience along with other benefits which have positive impacts on health outcomes.[1] Care Coordination is an essential systems change to improve client health, enhance client experience, reduce costs, and improve the work life for service providers. This is accomplished by increasing communication among service providers, and providing education, advocacy, and service linkage.

[1] Chuang et al., "Health Policy Brief: Whole Person Care Improves Care Coordination for Many Californians". *UCLA Center for Health Policy Research*, 2019.

To achieve this, WPC-C2H implements core Care Coordination components such as multidisciplinary team collaboration, adequate staffing, and shared processes and protocols.

92 Clients Received
Care Coordination through
Case Management Services

92 unduplicated clients received Care Coordination services through WPC-C2H Case Management in 2019. The three Case Managers average 30-35 clients each, with about 67% of clients receiving weekly services.

What is Working- *Care Coordination*

Systems Change and Service Strategy Shifts

Overall, WPC-C2H Care Coordination constitutes a significant change in the system of health care provision in Santa Cruz County and offers an overarching structure of service delivery that better serves the community. As demonstrated below, it represents a shift from service providers working in siloed efforts to providers working collaboratively to serve the whole person. WPC-C2H is built upon the foundation of support for the "whole person" on their path to wellbeing, acknowledging that all people have physical, mental, emotional, and social aspects to their health and wellness.

Core Component: Multidisciplinary Team Collaboration and Adequate Staffing

Two core components of Care Coordination are establishing multidisciplinary team collaboration and adequate staffing. Essential dimensions of WPC-C2H service provision include differentiated staffing, integration of care at the clinic level, trauma-informed trusting relationships with clients as partners in their care, advocacy for medical and social services, and countywide capacity building.

> "There's a real community that wants the best for everybody; there's a strong collaboration for our complex cases."
> -WPC-C2H Director

The foundation of Care Coordination are committed multidisciplinary teams representing the variety of sectors serving each client with complex needs, including: medical; mental health; substance use; and housing and other social service providers. This model requires the engagement and coordination of multiple agencies through intentional communication and partnership based on shared values and methods.[2] The details of how these teams operate within WPC-C2H are outlined in the Shared Processes and Protocols section below.

During implementation, WPC-C2H recognized that in order to scale services for clients with high needs, multiple staff working at different levels of care are required. Clients with complex needs require services ranging from specialized medical care to frequent transportation. WPC-C2H established differentiated staffing which equips Peer Support Coaches to provide transportation and Housing Navigators to search for housing, enabling Case Managers to focus on Care Coordination and direct services for clients.

Informed by best practices, the three WPC-C2H Case Managers were established as part of the clinical staff at the two primary County Integrated Behavioral Health clinics and supervised by clinically experienced staff. The Case Managers operate as the critical links among the multidisciplinary team members, serving as the primary contacts for the clients, and supporting them

[2] Humowiecki M, Kuruna T, Sax R, Hawthorne M, Hamblin A, Turner S, Mate K, Sevin C, Cullen K. Blueprint for complex care: advancing the field of care for individuals with complex health and social needs. www.nationalcomplex.care/blueprint. December 2018.

to make progress towards their health and social goals through education, advocacy, and service linkage. While many other social service programs implement multidisciplinary team collaboration and Case Management, most programs face an often insurmountable barrier when attempting to coordinate care with health care providers. WPC-C2H's success is in significant part attributable to its fully integrated team structure.

The Case Managers have achieved success with clients with complex needs through taking the time to build trusting relationships with their clients and other providers. They provide the time-intensive support, education, and service linkage that medical providers do not have the time to offer. Using a trauma-informed care approach, the Case Managers are able to see beyond the often challenging behaviors of clients and offer compassion and practical support. Empowered to do whatever it takes to support their clients, they serve as buffers between clients and highly stressful situations which enables clients to move forward with goals when they would otherwise become stuck.

"The primary role we play is supporting the client to make the next step. We can help them get 2-3 steps down the road toward their success when often they'd get stuck at the first roadblock. That's where the bridge normally collapses underneath them. All of these things are lined up so that if one link in the chain breaks they have to start over; we can hold that chain together."
-WPC-C2H Case Manager

One of the most valuable activities conducted by the Case Managers is advocating for their clients to receive adequate and effective care within the medical and social service systems which are not always organized to consider the entirety of a client's needs. With established data-sharing agreements, the Case Managers work with service providers to discuss the background of clients' needs and the positive impact of receiving care, for example a specialized medical service or placement in shelter. If needed, the Case Managers join clients for medical appointments to provide support and advocacy. This type of extensive client support by the Case Managers significantly relieves service providers' workloads, improving the work life experience of the service providers while addressing clients' needs for effective care.

Client Story:
After being expelled from one specialized medical provider, John's* Case Manager worked with several providers to advocate for him to be accepted into another.

During initial implementation, the WPC-C2H leadership team recognized the need for countywide capacity building in the area of Care Coordination. Between December 2018 and May 2020, the Care Coordination Networking Series provided seven capacity building sessions attended by 200 medical, behavioral health, and social service providers. The series included "Lightning Talks" at which agencies shared what services they provide and how to refer clients. The WPC-C2H Case Managers attended the entirety of the series. A list of topics is available in Appendix B.

Core Component: Shared Processes and Protocols

A core component of Care Coordination is establishing shared, consistent processes and protocols among the multidisciplinary team members. At the team level, these include the technological platform, data-sharing agreements, case conferencing meetings, client needs assessments, and shared care plans. At the Case Management level, these include a tiered system to identify client needs and services, and reduced documentation.

**Name has been changed*

To facilitate improved efficiency and real time Care Coordination among the different staff and agencies working with clients, the Together We Care (TWC) technological platform was selected and instituted. A separate report is forthcoming detailing the technological infrastructure and data-sharing component of the WPC-C2H program.

A non-negotiable process for Care Coordination is the establishment and utilization of a data-sharing agreement which clients use to permit the sharing of specific information among service providers to better serve them. Once agreements are established for each client, the WPC-C2H multidisciplinary teams convene in regular and ad-hoc case conferencing meetings to share essential information and work through challenges. Because the Case Managers are located within the clinic settings, they are able to seamlessly join the Integrated Behavioral Health meetings to share vital information and participate in treatment planning. In addition, client needs assessments and care plans are now shared through the TWC technological platform, and previously through the Electronic Health Records.

> "They're given a full access view of how to support clients in a way that other Case Managers don't get."
> -WPC-C2H Director

At the Case Management level, clients are identified within a tiered system to determine levels of need and WPC-C2H interventions. This has streamlined the internal process to ensure that resources are used optimally and Case Managers can focus on primary goals with clients. A unique aspect of the program which is critical for empowering Case Managers to facilitate time-intensive Care Coordination, is the reduced quantity of program documentation required. Unlike many medical programs and services, the WPC-C2H Case Managers are required to track and submit minimal documentation to maximize the amount of time they can invest in supporting their clients. This method allows case managers to reach more clients in an efficient and effective manner.

Opportunities to Improve System and Service Gaps- *Care Coordination*

The four primary areas to improve system and service gaps in the Care Coordination of WPC-C2H in Santa Cruz County are collaboration among key service providers; clarity of team member roles; additional Case Management services; and pre-established processes and protocols.

Core Component: Multidisciplinary Team Collaboration and Adequate Staffing

While WPC-C2H has generated significant increases in multidisciplinary team collaboration among medical, mental health, substance use, and social service providers, there are a few distinct areas for improvement. Notably, communication and collaboration has been limited between County Behavioral Health (providing psychiatric services for people with severe mental health conditions, formerly called Specialty Mental Health) and County Integrated Behavioral Health (providing medical and behavioral health services in the clinic settings). This has led to minimal Care Coordination taking place for WPC-C2H clients with severe mental health conditions. Ultimately, the Care Coordination and integrated services model is new to the County Behavioral Health Department and traditional silos remain slow to shift towards collective partnership.

Although WPC-C2H had the foresight to establish differentiated staff positions, there remains a lack of clarity around the specific roles best suited for each position. As the primary contact for clients, the Case Managers can find themselves stretched and taking on activities better suited to Housing Navigators, Peer Support Coaches or Medical Assistants, such as submitting housing documentation and providing transportation. Overall, additional Case Management services would enhance the

effectiveness of the program to decrease wait lists and fulfill the need for sustained long-term services.

Core Component: Shared Processes and Protocols

One of the most significant challenges to the implementation of WPC-C2H Care Coordination has been the lack of pre-established processes and protocols. Mechanisms for standardizing processes and data collection across Case Managers and partner agencies were not determined prior to program roll out. For example, instituting referral and eligibility protocols evolved over time and initially resulted in confusion among partners. Without set protocols and processes in place at the start of the program, Case Management methods were inconsistent and individualized based on staff's previous training and experience. Additionally, without a strong data collection process and evaluation system established at the onset, the WPC-C2H team was unable to collect the comprehensive data necessary to understand the full impact of the interventions.

Finally, there are several existing processes which WPC-C2H does not have the authority to streamline, such as the Housing Authority subsidized housing voucher application and the Social Security Insurance (SSI) application processes. These fixed system processes can contribute to lengthy wait times to obtain the financial resources necessary to move forward with housing and other client goals.

Summary

WPC-C2H works with the county's most vulnerable clients with complex needs. The evidence-based intervention of Care Coordination is an investment in the short term that yields significant long-term benefits to individuals and the community, such as improved client health, enhanced client experience, reduced long-term costs, and improved work life for service providers.

What is Working- *Care Coordination*	
Systems Change and Service Strategy Shifts	
Core Component: Multidisciplinary Team Collaboration and Adequate Staffing	Multidisciplinary cross-sector team collaboration ● Medical ● Mental health ● Substance Use ● Housing and other social services ● WPC-C2H Staff: Case Managers, Housing Navigators, Peer Support Coaches
	Case Management embedded at clinics
	Trauma-informed trusting relationships with clients as partners in their care
	Advocacy for medical and social services
	Countywide capacity building

Core Component: Shared Processes and Protocols	Technological platform for Care Coordination (Together We Care)
	Data-sharing agreements
	Regular case conferencing meetings
	Client needs assessments
	Shared care plans
	Tiered system to identify clients needs and services
	Reduced documentation
Opportunities to Improve System and Service Gaps- *Care Coordination*	
Core Component: Multidisciplinary Team Collaboration and Adequate Staffing	Collaboration among key service providers (County Behavioral Health and County Integrated Behavioral Health)
	Clarity of team member roles
	Additional Case Management services
Core Component: Shared Processes and Protocols	Pre-established processes and protocols

Appendix A: Whole Person Care - Cruz to Health Agency Partners

California Department of Health Care Services, Medi-Cal
Central California Alliance for Health
County of Santa Cruz Health Services Agency, Behavioral Health Department
County of Santa Cruz Human Services Department
County of Santa Cruz Probation Department
Dartmouth
Dignity Health Dominican Hospital
Encompass Community Services
Front St. Inc.
Health Improvement Partnership of Santa Cruz County
Housing Authority of the County of Santa Cruz
Housing Matters
Janus of Santa Cruz
NAMI Santa Cruz County
Netsmart
OCHIN
Philips Healthcare
Santa Cruz Health Information Exchange
Telecare
Watsonville Community Hospital

Appendix B: Care Coordination Networking Series Topics

- **December 2018**, “Shared definition of Care Coordination; Empathy-Based Care and Reduction of Stigma; Networking”
- **February 2019**, “Activities focused on shared definition of Care Coordination and shared understanding of best practices; Roles and Responsibilities and overlap/duplication; Networking”
- **May 2019**, “Empathic Care Practices and reduction of compassion fatigue; Lightning Talks; Networking”
- **July 2019**, “Deeper dive into Trauma Informed Care through small group sessions; Lightning Talks; Networking”
- **September 2019**, “CEU event featuring Vanessa De La Cruz: Improving Care Coordination in Complex Care Settings”
- **November 2019**, “Clinical learning via case examination; Networking”
- **May 2020**, “Discussing ways in which we can all continue to support patients in these unique circumstances, and provide advocacy in an overly stressed healthcare system, including through use of new techniques and tips surrounding tele-health”