

California program is a good step toward coordinating care for high-needs patients, study finds

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An [evaluation by UCLA researchers](#) has found that a California program launched in 2016 has been a positive step toward providing better-coordinated health care for people insured by Medicaid.

Initial findings from the ongoing analysis were published today by the UCLA Center for Health Policy Research. The researchers report that the state's Whole Person Care program has been successful on several fronts so far, including the sharing of patients' medical, [behavioral health](#) and social services data, which should enable providers to better collaborate to treat so-called "high-needs" patients.

That development is important in light of growing evidence that collaboration among medical, behavioral and social service providers can improve the [health](#) and well-being of people who frequently use [health services](#)—particularly those who are homeless or have mental health conditions. Nadereh Pourat, who led the evaluation and is the center's associate director, said the lack of coordination among doctors, [social workers](#) and other health providers has been one of the system's persistent and longstanding challenges.

Whole Person Care launched with 25 test programs covering 26 California counties; it is part of a California Department of Health Care Services effort to provide quality comprehensive care for people enrolled in Medicaid.

Among the researchers' key findings:

- All 26 locations provided "active referrals" to [medical care](#), behavioral [health care](#) and social services (meaning that workers made and attended appointments, and provided transportation assistance and follow-up).
- There were notable improvements in coordination and continuity of care because of the program.
- Data sharing capabilities improved. Seventeen centers (65 percent) had access to patients' medical, behavioral health and social [service](#) data, and 15 of them (58 percent) had data-sharing agreements with all key partners. Also, 21 centers (81 percent)

had access to patient data for frontline staff.

- Communication between the centers and patients was strong, with 23 centers (88 percent) reporting frequent, ongoing communication with enrollees.

However, the analysis found that the program, which is scheduled to continue through 2020, still needs to enhance data sharing across sectors, increase outreach to improve engagement with patients with complex needs, and make some other improvements to program infrastructure.

The authors assessed the extent to which the program met criteria that they developed for evaluating the successful coordination of medical and behavioral health care.

"The program addresses challenges such as providing transportation to appointments or translation services for patients with complex needs, which can require organizations to work together in new ways," said Emmeline Chuang, lead author of the paper and an associate professor at the UCLA Fielding School of Public Health. "We've identified elements of a framework that other organizations can use in considering how to successfully create their own programs and ultimately could influence policymakers and insurers to invest in the WPC approach to improve care for patients in California and beyond."

Pourat, who also directs the research center's Health Economics and Evaluation Research Program, said, "The data highlighted the value of continued investment in developing needed structure for care coordination, focusing on patient-centered practices that engage vulnerable patients and leveraging resources and partnerships to address limited availability of permanent housing. The program breaks down some of the barriers in our fragmented health care system and could pave the way for future models of care."

Provided by University of California, Los Angeles

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