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Care Coordination in California's Whole Person Care Pilot Program: Alameda County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots ([found here](#)). The following document describes care coordination under Alameda County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Alameda County Health Care Services Agency (HCSA) worked most closely with multiple county agencies (Behavioral Health Care Services, Community Development Agency, Emergency Medical Services, and Health Care for the Homeless), eight community partners, and two managed care plans (Anthem Blue Cross and Alameda Alliance for Health).

Eligible enrollees were identified using administrative data from partners, and successfully enrolled after being contacted by a community partner providing either a service bundle or a discrete service. Some enrollees received occasional discrete services as needed, while others were enrolled in more intensive service bundles for an average of 6 to 12 months

and graduated from WPC once they had achieved their goals.

The overall characteristics of Alameda's WPC Pilot called "Alameda County Care Connect" are displayed in Exhibit 1.

Exhibit 1: Alameda WPC Pilot Overview

Lead Entity	Alameda County Health Care Services Agency		
5-Year Projected Enrollment	17,000		
Enrollment Strategy	Administratively Enrolled		
Primary Target Population(s)	High Utilizers, Homeless		
35 Partner Organizations			
12 County Health and Mental Health	2 County Housing, Justice, or Social Services	3 Managed Care Plan	18 Community Partners ¹

Notes: ¹ Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Alameda focused on improving housing support, 30-day follow-up after psychiatric emergency services, high blood pressure control, and depression remission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Intensive care coordination services were provided primarily through the Care Management Service Bundles by community health workers (CHWs) supported by multidisciplinary teams of diverse specialists (e.g., nurses, social worker staff, primary care provider, and housing coordinators). Similar care coordination was also provided in the housing-related service bundles led by housing coordinators. Many CHWs and housing coordinators had personal lived experience similar to that of WPC target populations to help improve enrollee engagement. The caseload goal for CHWs was typically 30-35 enrollees, but in practice was closer to 20-25 depending on the community partner providing the service due to the time requirements that were more intensive than expected. Caseloads for the housing-focused service bundles ranged from 20-30.

Data sharing capabilities to support care coordination. By early 2019, Alameda County HCSA had executed data sharing agreements with some of its partners, including other county agencies, hospitals, community clinics, health plans, mental health and substance use treatment providers, and housing provider organizations. Alameda's Pilot also implemented a release of information form for eligible enrollees, but did not have a universal consent form used by all partners.

As part of WPC, Alameda's Pilot planned to launch a community health record (CHR) that would be used by all WPC partners to share relevant enrollee data. By early 2019, the Pilot had established a prototype CHR that was used by eight partner organizations. Features of the prototype CHR included a shared communication space, access to the care plan, and enrollment and eligibility data. Users of the CHR were also able to access shared data in real-time and in the field. WPC partners who did not use the prototype CHR typically utilized their own electronic systems to store and access enrollees' care plan. Alameda's Pilot planned to launch the permanent CHR, including shared

housing and social services data, by late 2019 and substance use disorder data by 2020.

Standardized organizational protocols to support care coordination. Alameda's Pilot included standardized protocols for referring enrollees to needed services. Protocols were developed by the Pilot's training program (called the Care Connect Academy), which was responsible for training participating providers and staff to effectively meet the needs of WPC enrollees. As of early 2019, Care Connect did not have standardized protocols for monitoring referral status and follow-up documentation, but was exploring this functionality for later additions to the CHR.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided through contracts with external service providers, rather than directly by HCSA. Alameda County HCSA was reimbursed for care coordination services using two, risk-stratified per-member-per-month (PMPM) bundles under the Care Management Service Bundle: Tier 1 moderate-intensity care coordination and Tier 2 high-intensity care coordination for those with serious mental illness and/or experiencing homelessness. HCSA was reimbursed for care coordination as a part of the housing-related service bundle using three risk-stratified tiers. External partners were also paid on a fee-for-service basis for discrete services and received financial incentives for achieving identified outcomes. For example, partners were provided incentive payments for achievements such as improving access and quality of care for WPC enrollees, and improving electronic data collection and reporting.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Alameda's Pilot utilized a person-centered approach for communicating with enrollees. Initial contact was made in the field wherever enrollees could be found (e.g., hospital, at their homes, in homeless encampments, on the street, and other

locations). Ongoing communication primarily occurred face-to-face with a reported average of three times per month. The Pilot identified in-person outreach as critical for enrollee engagement.

Conduct needs assessments and develop comprehensive care plans. CHWs performed a formal needs assessment of physical health, behavioral health, and social needs (e.g., housing) at intake into the care management service bundle, and updated with additional assessments throughout the year as appropriate. Needs assessment results were used to develop a comprehensive care plan with enrollee-driven goals electronically accessible to providers (either via the CHR or a partner organization's internal EHR or case management platform).

Actively link patients to needed services across sectors. Alameda's WPC CHWs used active referral strategies to refer their enrollees to needed services. All staff involved in care coordination received training through the Care Connect Academy on how to effectively link enrollees to needed services across the system of care, particularly primary care. Depending on the needs of the particular enrollee, this included scheduling follow up appointments, arranging for transportation, and attending those appointments alongside the enrollee, when appropriate.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team providing the housing-related service bundle, Alameda's Pilot required multidisciplinary care coordination teams to participate in two-hour, bi-weekly case conferencing meetings. At each meeting, teams discussed the needs and concerns of approximately 50 of the most vulnerable enrollees. Additional providers from other sectors were encouraged to join to support linkages across the system of care.

Suggested Citation

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