UCLA CENTER FOR HEALTH POLICY RESEARCH

Health Policy Case Study

October 2019

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

Leigh Ann Haley, MPP, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

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 Contra Costa County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Contra Costa Health Services (CCHS) worked most closely with Employment and Human Services, one managed care plan, one regional medical center, and three community partners.

Eligible enrollees were identified using a predictive risk model that drew on linked data from multiple sources (e.g., medical records from clinics and hospitals, claims from the health plan and outside providers, the Sheriff's Department, and the County Public Health Agency's case management system). Enrollees were evaluated at 12 months for continued services or graduation.

The overall characteristics of Contra Costa's WPC Pilot called "CommunityConnect" are displayed in Exhibit 1.

Exhibit 1: Contra Costa WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">Contra Costa Health Services (CCHS)</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">42,000</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Predictive Risk Modeling with Two Risk Levels</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers</td></tr>
<tr><td colspan="4">11 Partner Organizations</td></tr>
<tr><td>4 County Health and Mental Health</td><td>1 County Housing, Justice or Social Services</td><td>1 Managed Care Plan</td><td>5 Community Partners[1]</td></tr>
</table>

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

To achieve the goals of better care and health, Contra Costa's WPC Pilot focused on developing patient-centered care plans. The Pilot reported on improvement in self-reported health status and quality of life, suicide risk assessment and depression remission rates, and SBIRT screening rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. CCHS hired 150 staff for WPC, all with offices in a central location specifically dedicated to WPC. Care coordination services were provided by multidisciplinary teams led by supervisors. Each team was organized to include diverse specialists (e.g., public health nurses, mental health counselors, substance abuse counselors, community health workers (CHWs)). The Pilot included some care coordinators with personal lived experience similar to that of WPC target populations to help improve enrollee engagement. Housing and tenancy support services were provided directly by care coordinators. However, the Pilot also contracted with the Employment and Human Services division to hire three Social Service Agency Eligibility Specialists to assist with applications to public benefits and twelve social workers to assist enrollees with navigating other benefits (e.g., in-home supportive services). Expansion plans in 2019 included the addition of four social workers specializing in the area of In-Home Supportive Services.

Tier 1, or high risk, enrollees were assigned to a single care coordinator whose specialty was best aligned with the enrollee's needs and received field-based services. Tier 2, or lower risk, enrollees were typically assigned to a CHW and received telephonic care coordination services. However, ownership and responsibility for all enrollees was shared across the multidisciplinary team, and care coordinators could request consults from other members of their interdisciplinary team when needed.

In early 2019, the average caseload was 90 clients for care coordinators working with Tier 1 enrollees and 350 clients for care coordinators working with Tier 2 enrollees. With the introduction of a WPC budget modification in late 2018, CCHS reported plans to reduce the caseloads to 80 and 250 for care coordinators working with Tier 1 and Tier 2 enrollees, respectively.

Data sharing capabilities to support care coordination. By early 2019, CCHS executed data sharing agreements with all of its partners, including the County Employment and Human Services agency. To facilitate data sharing, Contra Costa relied on a universal consent form among all WPC partner organizations.

All key WPC partners utilized the same electronic health record, Epic, which greatly streamlined data sharing efforts. Linked data available in Epic were comprehensive, and included medical data from clinics and hospitals, behavioral health data from the County Behavioral Health Department, and data from Public Health. Additional data from outside providers, including the Sheriff's Department and social services data from the Homeless Management Information System, were included in workflows with integration via the county's data warehouse.

Care coordinators used Epic to record and track daily activities, monitor enrollee progress, communicate with providers, and develop dashboards and reports to monitor metrics. To help promote a person-centered approach to enrollee engagement, care coordinators were able to access Epic on mobile laptops or other devices in the field. Care coordinators also received real-time notifications if enrollees visited the Emergency Department (ED), or were admitted to an inpatient setting or the County's detention facility.

Standardized organizational protocols to support care coordination. Contra Costa's Pilot included standardized protocols for referring enrollees to needed services, monitoring referral status, and documenting any follow-up. Behavioral health service referrals were coordinated via the Behavioral Health Access Line, a call center that enters and processes all behavioral health service referrals in the county.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided directly by CCHS, rather

than through contracts with external service providers. CCHS was reimbursed for WPC care coordination services primarily through two per-member per-month (PMPM) bundles that paid a set amount per enrolled person.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Contra Costa's Pilot initiated outreach via welcome letters and phone calls to eligible enrollees. Direct field outreach was utilized to contact hard-to-reach individuals. The majority of ongoing communication with Tier 1 enrollees occurred via in-person field visits (e.g., home, community space, shelter, library, doctor's office) that took place between one and three times per month. For Tier 2 enrollees, all communication was telephonic and occurred at least every two months. Care coordinators were expected to follow-up on high-risk notifications (e.g., ED utilization) within 72 hours of receipt.

Conduct needs assessments and develop comprehensive care plans. Care coordinators initiated a formal needs assessment at intake and completed the process in the first few weeks or months of enrollment. The Pilot used an interactive process to develop a comprehensive care plan with client-driven goals that often evolved over the enrollment period. Comprehensive care plans were maintained in Epic and accessible to all key WPC partners.

Actively link patients to needed services across sectors. Contra Costa's WPC care coordinators used active referral strategies to refer their enrollees to needed services, particularly those in Tier 1. For example, all care coordinators either directly scheduled medical appointments for enrollees or actively taught enrollees how to schedule their own appointments using an advice nurse or online portal. Care coordinators were required to refer enrollees to the Behavioral Health Access Line to make appointments for behavioral health services, but reported arranging these appointments jointly with enrollees when needed. In addition to medical and behavioral health resource referrals, WPC care coordinators also had access to a comprehensive social resource database which they used to provide resource referrals. These referrals were then tracked and followed up through their Epic care plan.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Contra Costa's Pilot required in-person, bi-monthly meetings for multidisciplinary teams and specialties (e.g., Public Health nurses). Multidisciplinary team members were also deliberately co-located in the same office space to promote communication and accountability.

Suggested Citation

Haley LA, Chuang E, Albertson E M., Lu C, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Contra Costa County*. Los Angeles, CA: UCLA Center for Health Policy Research.