Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Kern 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 Kern County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Kern Medical Center (KMC) worked most closely with three county agencies (Housing Authority, Department of Human Services and the Sherriff's Office), two managed care plans, and four community partners.

Eligible enrollees were initially identified using lists of individuals meeting target population criteria from two local health plans. However, the Pilot found that these lists did not contain current contact information and were not successfully identifying individuals that were homeless or at-risk-of-homelessness, or those that were recently incarcerated or soon-to-be-released. Therefore, the Pilot updated their enrollment strategy to a referral-based system

from the housing authority and a jail-based physician.

Enrollees were asked to complete a six-course series (for the foundational WPC Care Coordination bundle) aimed to prepare them to coordinate their own care before assessing their readiness to graduate from the program.

The overall characteristics of Kern's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Kern WPC Pilot Overview

Lead Entity	Kern Medical Center (KMC)		
5-Year Projected Enrollment	2,000		
Enrollment Strategy	Health Plan Administrative Data, Referrals		
Primary Target Population(s)	High Utilizers, Homeless, At-Risk-Of-Homelessness, Justice-Involved		
15 County Health and Mental Health			
3 County Health and Mental Health	5 County Housing, Justice or Social Services	2 Managed Care Plan	5 Community Partners[2]

Notes: [1]Initially enrollment was based on administrative data, but later switched to a referral-based system [2]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, Kern's WPC Pilot focused on improving blood pressure and diabetes control, suicide risk assessment and depression remission rates, successful housing and supportive housing, and hospital readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. At Kern, care coordination services were provided by KMC medical assistants, supported by two physician champions, a social worker, a nurse practitioner, a PharmD, and a team of health educators. To promote continuity, medical assistants were responsible for outreach, enrollment, and provision of care coordination services. Caseloads for medical assistants varied depending on the type of enrollees they were assigned, but were typically no more than 125-150.

Data sharing capabilities to support care coordination. By early 2019, the Pilot had data sharing agreements in place with some but not all partners. Many community-based partners were described as reluctant to use KMC's data systems in lieu of their own, established data systems. Despite this challenge, Kern's Pilot was able to successfully develop a universal consent form used by all partners. The Pilot held enrollee care plans in KMC's electronic medical record. Due to limited data sharing across partners, not all partners were able to access or view the care plan.

Care coordinators used KMC's electronic health record and associated care coordination software to track and monitor referrals, access enrollee data, and update enrollee records to reflect WPC activities. However, care coordinator access to enrollee data was limited and did not include all relevant behavioral health and social services data. Care coordinators also did not have real-time notifications of emergency department visits or remote access to data.

Standardized organizational protocols to support care coordination. Kern's WPC Pilot used standardized protocols to make, track, and

monitor referrals. Referrals for social services were made by care coordinators, while all medical and behavioral health referrals were made by clinicians and followed-up on by the care coordinators. Care coordinators followed protocols in the Pilot's care coordination software to track and close the loop on all referrals.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided by KMC, and funded primarily via two per-member-per-month (PMPM) bundles: 1) the WPC Care Coordination bundle and 2) the 90-Day Post-Incarceration Coordination bundle. The WPC Care Coordination bundle entailed care coordination by a multi-disciplinary team to address physical, behavioral health, and social service needs. The 90-Day Post-Incarceration bundle was specifically designed for individuals recently released from jail and services were tailored to meet specialized needs of this population, including specific courses geared around relevant topics for post-incarcerated enrollees, such as family reunification, recidivism reduction, and job readiness.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Care coordinators were responsible for outreach to potential enrollees at community events and/or by following up on referrals from partners. A physician co-located at the jail was responsible for outreach to potential enrollees prior to release from incarceration and connecting them to a medical assistant. Most contact for health plan referrals was telephonic, but the Pilot also tried to create opportunities for care coordinators and clients to meet in-person. Enrollees were assessed for their acuity level, which determined the frequency of ongoing communication: ranging from monthly for the lowest acuity level to weekly for the highest acuity level.

Conduct needs assessments and develop comprehensive care plans. Care coordinators

did not directly conduct needs assessments but were instead responsible for setting up appointments with a primary care physician and a social worker. At these appointments, the clinicians were responsible for performing a comprehensive biopsychosocial assessment. Assessment results were used to identify enrollee's physical, behavioral health, and social service needs, and served as the basis for developing a comprehensive care plan. Some assessments, including the PHQ-9 were repeated quarterly to track enrollee progress. Care plans were not standardized and could vary based on enrollees' needs. Only partners with access to KMC's medical record could view the care plan.

Actively link patients to needed services across sectors. Care coordinators in Kern provided active referrals for medical, behavioral health, and social services. For example, once enrolled, care coordinators were responsible for helping schedule a primary care appointment for every enrollee and for all other medical referrals ordered through the electronic medical records. Care coordinators were also permitted to directly schedule appointments with partnering behavioral health providers. All referrals made to partners external to KMC were kept as notes in the enrollee's medical record and were tracked using the Pilot's care coordination software.

Promote accountability within care coordination team. To promote accountability, the WPC manager checked in with staff at least daily and held a weekly WPC meeting where the care coordination team could openly discuss enrollment, goals, and challenges. Additionally, the team communicated regularly through email.

Suggested Citation