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

Background

To implement WPC, Kings County Human Service Agency (HSA) worked most closely with two county agencies (Behavioral Health and Public Health) and one community partner (a non-profit behavioral health and social service provider).

Eligible enrollees were identified using a referral system, including self-referrals. A multidisciplinary team met with each prospective enrollee to assess needs, determine eligibility for WPC services, and assign an ongoing care coordinator. Enrollees typically stayed in the program for 4-12 months or until they achieved their care goals.

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

Exhibit 1: Kings WPC Pilot Overview

Lead Entity	Kings County Human Service Agency (HSA)		
5-Year Projected Enrollment	600		
Enrollment Strategy	Referrals-Based System		
Primary Target Population(s)	Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder		
8 Partner Organizations			
2 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	3 Community Partners ¹

Notes: ¹ Community partners include services for housing, health, mental health, 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, Kings' WPC Pilot focused on reducing untreated severe mental illness and substance use disorders, increasing assessments of suicide risk, decreasing jail recidivism, and improving chronic care management.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by care coordinators with varied backgrounds and experience (e.g., social work,

substance abuse counseling, on-the-job training through WPC only). There were also two acute care coordinators, who specialized in mental health counseling and were responsible for providing care coordination services to the highest acuity enrollees. The caseloads for acute care coordinators and general care coordinators were kept deliberately low at 10 and 20 enrollees, respectively, to ensure care coordinators had adequate time to work closely with enrollees.

Care coordinators also had access to support from a larger, multidisciplinary team (MDT) that included a housing navigator, job navigator, community health worker, and eligibility specialist. The eligibility specialist was responsible for working with enrollees to ensure they could access all public assistance they were qualified for (e.g., adult protective services and/or in-home supportive services). Kings also developed a peer specialist role using individuals with lived experience to help outreach and engage homeless enrollees.

Data sharing capabilities to support care coordination. By early 2019, Kings County HSA had executed data sharing agreements with most partners. To facilitate data sharing, the Pilot implemented a universal consent form among all WPC partner organizations. For enrollees experiencing homelessness, an additional, separate consent form was still required by the local Coordinated Entry System (CES), which was not a WPC partner organization.

The Pilot provided all partner organizations with access to an electronic case management platform (called ETO) to view enrollees' comprehensive care plans. Care coordinators used ETO to perform and track all care coordination activities. Data included in ETO was comprehensive, and included medical, behavioral health, and social services data from the county's behavioral health and human services agencies and the community-based partners responsible for care coordination. Care coordinators could access the system in the field,

but did not receive any real-time updates about enrollee service utilization.

Standardized organizational protocols to support care coordination. Kings' Pilot included standardized protocols for referring enrollees to medical, behavioral health services, and social services. To monitor and follow-up on referrals, the Pilot relied on weekly status reports from the hospital and required care coordinators to directly contact partner organizations to check on referral status.

Financial incentives to promote cross-sector care coordination. The majority of care coordination services were contracted out to a single community partner, which was funded primarily through a per-member-per-month (PMPM) bundle. High acuity care coordination was provided by the county behavioral health department and was funded through a second PMPM bundle. The Pilot also received fee-for-service reimbursement for initial outreach and engagement of enrollees.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Kings' Pilot used in-person outreach to engage potential enrollees, including office, home, and community visits. Community visits included weekly visits at a church that served food to the underserved and homeless. Once enrolled in the program, care coordinators typically continued to contact enrollees at least once per week in-person, via telephone, or out in the community.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Specifically, a comprehensive needs assessment was typically conducted by a community health worker, care coordinator, and eligibility specialist. Results were reviewed by the MDT to determine eligibility for WPC, set preliminary care plan goals, and assign a care coordinator. Prospective enrollees were still not officially enrolled in WPC until after the care coordinator convened an initial care plan meeting including

all cross-sector care providers already working with the enrollee. Care coordinators were responsible for uploading the care plan in ETO and continued to screen enrollees every six months to update the care plan, set goals, and/or determine when enrollees were eligible for graduation from WPC.

Actively link patients to needed services across sectors. Kings' WPC care coordinators used active referral strategies to refer their enrollees to needed services. For example, care coordinators tailored service recommendations based on enrollees' past experiences with local service providers and facilitated access to a primary care physician if enrollees did not already have a usual source of care.

Promote accountability within care coordination team. In order to increase accountability within the care coordination team and facilitate communication between multidisciplinary team members, care coordinators and the MDT were located in close proximity to one another in the same office. Care coordinators were able to access specialized knowledge of the MDT, which met weekly to discuss enrollee needs and progress.

Suggested Citation

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