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

Background

To implement WPC, Marin County Department of Health and Human Services (HHS) worked most closely with county agencies (Health and Human Services: Behavioral Health and Recovery Services, and the Marin Housing Authority), one managed care plan, six community partners providing contracted WPC case management (including three out of four of Marin's federally qualified health centers) and a number of other community partners.

Eligible enrollees were identified using administrative data from the county's Coordinated Entry System. The Pilot also accepted referrals from community health clinics. The Pilot prioritized enrollment of the top 10% of Medi-Cal beneficiaries based on emergency department utilization that also were homeless, had complex medical conditions, had behavioral health issues, and/or lacked social supports identified as interfering with adherence to treatment. Length of enrollment in the program varied depending on the services needed by the client.

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

Exhibit 1: Marin WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">Marin County Department of Health and Human Services (HHS)</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">3,200</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Administrative Data and Referrals</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers, Homeless, At-Risk-of-Homelessness</td></tr>
<tr><td colspan="4">29 Partner Organizations</td></tr>
<tr><td>2 County Health and Mental Health</td><td>4 County Housing, Justice, or Social Services</td><td>1 Managed Care Plan</td><td>22 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 better health, Marin's WPC Pilot focused on using assessments, improving housing support, and improving self-reported health status.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by care coordinators whose qualifications varied depending on the type of enrollees served. For example, care coordinators for medically complex enrollees were registered nurses supported by medical assistants. For enrollees with mild-to-moderate mental illness, the care coordinator was a licensed clinical social worker or social work student supervised by a licensed clinical social worker. Many housing care coordinators had lived experience similar to that of enrollees, which facilitated outreach and engagement. Care coordinator caseloads varied across organizations and by type of case management, ranging from 17 to 30 enrollees.

WPC enrollees could also receive additional support from dedicated benefit support specialists, housing support specialists, and physicians within WPC partner organizations.

Data sharing capabilities to support care coordination. By early 2019, Marin HHS had executed data sharing agreements with all partner organizations and was actively sharing medical, social service, and some behavioral health data through the county's health information exchange. To facilitate data sharing, Marin implemented a universal consent form that all WPC partner organizations used during enrollment.

Marin HHS also implemented an electronic care coordination platform to provide partners with access to enrollee data, including the comprehensive care plan, and help track care coordination activities. The platform included an internal messaging tool with chat functions to facilitate communication between providers. Care coordinators were able to access the platform in the office and in the field.

Standardized organizational protocols to support care coordination. Marin's WPC Pilot included standardized protocols to monitor and follow-up on key elements of care coordination, but the Pilot chose not to develop standardized service referral protocols. Rather, they provided intensive case management, which included connecting clients to and with any services judged necessary.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided through contracts with external providers, and specifically with local community partners. The Pilot's care coordination services were funded primarily through three per-member per-month (PMPM) bundles: a housing-based case management bundle, a comprehensive case management bundle and a case management bundle for individuals with mental health conditions and complex psycho-social challenges but do not meet criteria of severe mental illness for County Behavioral Health Services. Enrollees were placed into service bundles based on primary need rather than acuity. The Pilot also received fee-for-service reimbursements for care management referrals, screening and assessments, housing support, engagement, and care plan development. Partners received financial incentives for achieving specific outcomes, such as developing a comprehensive care plan within 30 days of enrollment and ensuring high participation in case conferences.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Marin's WPC Pilot used a variety of methods to initiate contact with eligible enrollees, depending on the partner organization and enrollee needs. For example, initial contact with homeless enrollees typically occurred in the field, while initial engagement of medically complex enrollees typically occurred in the clinic. After enrollment in WPC, most communication between care coordinators and enrollees occurred in-person. On average, care coordinators contacted WPC enrollees 3.8 times per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, with a subset of assessments repeated annually.

Assessment tools included the Patient Health Questionnaire-9 or PHQ-9 for depression, a suicide risk assessment, and an assessment of social determinants of health. Care coordinators were required to work with enrollees to develop a care plan with person-centered goals. Care plans include at least one client-identified goal, and plans were updated frequently as enrollees met existing goals and identified new ones.

Actively link patients to needed services across sectors. Marin's WPC care coordinators used active referral strategies to refer their enrollees to needed services, including medical, behavioral health, and social services. For example, care coordinators often scheduled appointments for enrollees and accompanied them to their appointments. Active referral processes were described as successful in linking previously resistant enrollees to services. Dedicated staff to assist enrollees through the benefit enrollment and renewal process were also identified as an important resource for overcoming barriers to accessing care.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Marin's pilot required care coordinators to participate in bi-weekly case conferences. One partner used daily triage meetings to review previous day interactions with enrollees, schedule activities for the current day, and discuss questions related to enrollee care.

Suggested Citation

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