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

### Background

To implement WPC, Mariposa County Human Services Department (MCHSD) worked most closely with two county agencies (Behavioral Health Services and Employment and Community Services), the local health care district, two local managed care plans, and a community-based health and social services provider.

Eligible enrollees were identified through referrals from partner agencies and targeted outreach to managed care plan lists of high utilizers. Care coordinators were responsible for contacting potential enrollees to assess eligibility and schedule an initial meeting.

Mariposa's WPC Pilot was a member of the Small County Whole Person Care Collaborative (SCWPCC), along with San Benito.<sup>1</sup> Although counties in the collaborative shared some infrastructure and processes, each county's program was distinct.

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

Exhibit 1: Mariposa WPC Pilot Overview

<b>Lead Entity</b>	Mariposa County Human Services Department (MCHSD)		
<b>5-Year Projected Enrollment</b>	87		
<b>Enrollment Strategy</b>	Referrals and Targeted Outreach		
<b>Primary Target Population(s)</b>	High Utilizers, Severe Mental Illness and/or Substance Use Disorder		
<b>10 Partner Organizations</b>			
2 County Health and Mental Health	4 County Housing, Justice, or Social Services	2 Managed Care Plan	2 Community Partners <sup>2</sup>

Notes: <sup>2</sup> 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, Mariposa's WPC Pilot focused on improving suicide risk assessment rates, housing services, implementing a uniform housing

<sup>1</sup> Plumas County was initially a member of the collaborative, and subsequently ended their participation in WPC.

assessment tool, and reducing hospital readmission rates.

### Care Coordination Infrastructure

**Care coordination staffing that meets patient needs.** Care coordination services were provided by a multi-disciplinary team, with care coordinators trained in mental health receiving support from a part-time licensed vocational nurse and nurse practitioner, and a housing navigation team comprised of staff with lived experience similar to that of WPC enrollees. Average care coordinator caseload was 20 to 25 enrollees.

**Data sharing capabilities to support care coordination.** By 2018, MCHSD executed data sharing agreements with all of its partners. To facilitate data sharing, Mariposa implemented a universal consent form among all WPC partner organizations.

MCHSD also implemented an integrated data management system called eWPC that contained medical, behavioral health, and social services information. All key partners were included in this integrated data sharing platform, except the local health care district which did not join the system due to the extensive resources required to learn and implement a new data platform. Care coordinators were trained in use of the new system. To help promote a person-centered approach to enrollee engagement, staff were provided tablets they could use to access the database in the field. Although most data was stored in eWPC, care coordinators reported that some data still needed to be manually collected from other sources, such as lab reports. Care coordinators did not receive real-time notifications if enrollees visited the hospital or emergency department. They received calls from staff at the time of the visit, though not consistently. Real-time notifications were a future goal of the eWPC system.

**Standardized organizational protocols to support care coordination.** Mariposa's WPC Pilot included standardized protocols for referrals using standardized checklists and

protocols for administering assessments at intake. However, they had not yet developed a written protocol for monitoring and following up on referrals. A typical process was to review enrollee charts and act accordingly based on enrollee needs.

**Financial incentives to promote cross-sector care coordination.** All care coordination services were provided directly by MCHSD, rather than through contracts with external service providers. However, housing navigation services were contracted out. MCHSD was reimbursed for WPC care coordination services primarily through a single per-member-per-month (PMPM) bundle that paid a set amount per enrolled person. A second PMPM bundle also funded the housing support services that were contracted out.

### Care Coordination Processes

**Ensure frequent communication and follow-up to engage enrollees.** Mariposa's WPC Pilot mainly used in-person communication with enrollees, both during outreach and on-going communication. Care coordinators were expected to contact enrollees at least once per week. This approach was particularly important for engaging enrollees who were homeless.

**Conduct needs assessments and develop comprehensive care plans.** Care coordinators performed a formal needs assessment at intake. Certain assessments, such as the Patient Health Questionnaire-9 or PHQ-9 depression screening, were repeated every six months or potentially even more often for enrollees with a high score. Care coordinators developed a single comprehensive care plan for each enrollee and this plan was shared with all relevant partners using eWPC. When the care plan was needed by partners not on eWPC, Mariposa developed a system that allowed them to share the care plan with these partners.

**Actively link patients to needed services across sectors.** Mariposa's WPC care coordinators used active referral strategies to refer their enrollees to needed services. Care

coordinators made appointments for enrollees by phone, and sometimes accompanied enrollees to appointments. The Pilot also established an arrangement with the local health care district to provide WPC enrollees with priority appointments.

**Promote accountability within care coordination team.** In order to ensure accountability within the care coordination team, Mariposa's WPC Pilot required care coordinators to meet regularly, including several times per month with supervisors and other administrators, in order to organize care for each enrollee and to work on improvement projects. The entire multi-county SCWPCC leadership group met quarterly.

### **Suggested Citation**

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