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

Background

To implement WPC, Mendocino County Health and Human Services Agency (HHSA) worked most closely with one administrative service organization (Redwood Quality Management Company) and three community partners (Adventist Health Ukiah Valley, Mendocino Coast Clinics and Mendocino Community Health Clinics).

Eligible enrollees were identified using referrals. The Pilot evaluated enrollees every 180 days to determine if the enrollee still needed WPC services. In January of 2019, the Pilot implemented a formal graduation system.

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

Exhibit 1: Mendocino WPC Pilot Overview

Lead Entity		Mendocino County Health and Human Services Agency (HHSA)	
5-Year Projected Enrollment		550	
Enrollment Strategy		Referrals	
Primary Target Population(s)		Severe Mental Illness and/or Substance Use Disorder	
10 Partner Organizations			
3 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	4 Community Partners[1]

Notes: [1] 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, Mendocino's WPC Pilot focused on restoring and strengthening the medical and social support system for individuals with severe mental illness and two other qualifying conditions, including substance use disorder, high utilizers of medical expenses, homelessness, or recent law enforcement contact. Specifically, the Pilot focused on improving care through housing support, improving health through increased control of diabetes and hypertension, and improving social connections.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by diverse, multidisciplinary teams that varied by enrollee but could include peer support workers with lived experience similar to that of enrollees (called "Wellness Coaches" by the Pilot), nurses, mental health counselors, housing and benefit support staff, substance abuse counselors, community health workers, social workers, and/or physicians or nurse practitioners as needed. Wellness Coaches typically served as the primary point of contact for enrollees and were responsible for outreach and engagement. The average caseload per wellness coach was 15-20 enrollees and was purposively designed to include a mix of higher acuity and lower acuity enrollees.

Data sharing capabilities to support care coordination. By early 2019, Mendocino County HHSA had executed data sharing agreements with all of its partners with the exception of the managed care health plan, where a data sharing agreement was pending. To facilitate data sharing, the Pilot also implemented a universal consent form that was developed collaboratively and utilized by all community partners.

Also by early 2019, Mendocino's WPC Pilot had procured but not yet implemented an electronic care coordination platform (Vertical Change). To facilitate data sharing until this platform could be implemented, all participating community partners utilized a document-sharing platform called ShareFile. Wellness coaches utilized ShareFile to access enrollment forms, universal consent forms, enrollee care plans, medication lists and other documents needed to coordinate care for enrollees. Data in ShareFile were static, but included information on enrollee medical and behavioral health service utilization.

Standardized organizational protocols to support care coordination. Mendocino's Pilot did not include standardized protocols for referral pathways, or for monitoring and follow-up of referrals. However, each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. All care coordination services were contracted out to external service providers, who were provided with financial incentives for achieving milestones or performance targets and attending collaborative care meetings. Mendocino County HHSA was reimbursed for care coordination services primarily through two per-member-per-month (PMPM) bundles, which were assigned based on enrollee acuity (high vs. low).

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Mendocino's WPC Pilot used Wellness Coaches to initiate contact with potential enrollees, and to schedule an intake meeting if the individual was interested. The majority of ongoing communication occurred in-person through field visits, but could also include telephonic communication. Wellness coaches were expected to contact enrollees on a weekly basis.

Conduct needs assessments and develop comprehensive care plans. Wellness Coaches or other agency staff completed an intake process that included a list of questions that helped identify the area of need for each of the enrollees. Comprehensive care plans were maintained in ShareFile and accessible to all key WPC partners. Once the client was enrolled, the Wellness Coach assisted in making an appointment for a biopsychosocial assessment if one had not been done in the last year, as well as performing the Vulnerability Index-Service Prioritization Decision Assistance Tool or VI-SPDAT.

Actively link patients to needed services across sectors. Mendocino's WPC wellness coaches used active referral strategies to refer their enrollees to needed services and ensure they received needed services. For example, Wellness Coaches accompanied enrollees to scheduled medical or behavioral health

appointments and assisted in enrolling them in social services and benefits.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Mendocino's WPC Pilot required multidisciplinary team members to participate in care conference meetings every three months. Wellness Coaches also participated in monthly trainings and supervisory meetings.

Suggested Citation

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