Health Policy Case Study

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

Background

To implement WPC, Monterey County spearheaded its effort through Monterey County Health Department (MCHD) (primarily through its Public Health and Behavioral Health Bureaus) and worked closely with the county's Department of Social Services. An initial cadre of community partners included the Continuum of Care agency, a number of homeless services providers, and two low-income housing developers.

To identify potential enrollees, Monterey's WPC Pilot relied on high utilizer data generated by the county-owned safety-net hospital and referrals from other partnering homeless services agencies. The Pilot prioritized enrollment of homeless Medi-Cal beneficiaries with

comorbidities and/or a history of high utilization of the medical system.

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

Exhibit 1: Monterey WPC Pilot Overview

Lead Entity	Monterey County Health Department (MCHD)
5-Year Projected Enrollment	412
Enrollment Strategy	Referrals and Direct Outreach
Primary Target Population(s)	Homeless
16 Partner Organizations	
4 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	9 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, Monterey's WPC Pilot focused on improving blood pressure and diabetes control, substance use disorder assessments and counseling, suicide risk assessment and depression remission rates, successful long-term housing, hospital readmission rates, and discharge follow-up rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Four two-person teams primarily provided care coordination services. Each team included a public health nurse (PHN) case manager and an assistant, typically either a licensed vocational nurse (LVN) or behavioral health aide. The PHN was responsible for prioritizing enrollee needs and delegated remaining care coordination activities to his/her assistant. The Pilot focused on hiring staff with a public health background and experience working with impoverished individuals with chronic diseases. Average PHN caseload was approximately 40 enrollees.

The PHN and assistant teams had access to a multidisciplinary team of care coordination support staff, including social workers, alcohol and other drug treatment providers, mental health clinicians, benefit specialists, and housing specialists. As enrollee needs required, the PHN and assistant teams would work with these care coordination support staff to ensure enrollees received specialized care.

Data sharing capabilities to support care coordination. By early 2019, Monterey's WPC Pilot had data sharing agreements executed with all key partners, including the county's managed care plan, hospitals, and social services and community partners. Monterey's WPC Pilot relied on a two-step consent process in lieu of a single universal consent form. The first consent provided WPC with permission to access data needed to confirm an individual's eligibility for WPC. The second consent for data sharing was required to officially enroll individuals into the program and grant WPC permission to share the enrollee's medical, behavioral health, substance use, and HIV/AIDS status with specific entities.

Care coordinators reported using an existing electronic health record, Epic, to create and access enrollee care plans, track care coordination activities, and access other enrollee health data. Behavioral health data and service utilization were sourced from Avatar. Care coordinators were able to access Epic while in the field, and were able to access Monterey County Clinic services data, but were not able to access real-time updates regarding external service utilization (e.g., emergency department visits).

WPC partners could not access the care plan or other enrollee data unless they already had Epic, and in early 2019, Monterey's WPC Pilot was in the process of procuring new case management software to better support WPC activities.

Standardized organizational protocols to support care coordination. Monterey's WPC Pilot had protocols in place for referring enrollees to needed services, including for common conditions such as diabetes, hypertension, and depression. Given that the Pilot utilized PHNs as their primary care coordinators and the PHNs often had experience in providing home-based care, standard protocols for monitoring and follow-up were in place prior to implementation of WPC.

Financial incentives to promote cross-sector care coordination. Care coordination services were provided by MCHD and through contracted service providers. Care coordination services provided by the PHN and assistant teams were funded primarily through a single per-member-per-month (PMPM) bundle. Additional care coordination services, include but are not limited to a sobering center, housing placement services, tenancy support, mobile crisis team, and a homeless learning and wellness center, were funded as fee-for-service. To encourage care coordination services through their contracted providers, Monterey provided incentive payments for ensuring enrollees had medical and behavioral follow-up appointments within 30 days of hospital discharge.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Upon receiving a referral, PHNs and their assistants attempted to contact potential enrollees either by telephone or through field-based outreach. Completion of the two-step consent process was required for enrollment. Following enrollment, ongoing communication between care coordinators and enrollees occurred mostly in-person and several times a month until an enrollee's condition was more stable.

Conduct needs assessments and develop comprehensive care plans. All enrollees received a comprehensive needs assessment that included assessment of vulnerability, social needs, and the Patient Health Questionnaire-9 or PHQ-9 for depression. Enrollee needs were assessed at least once a year and more often as needed, and results were used to inform development of comprehensive care plans, which were stored in Epic. WPC external partners did not have access to Epic.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to ensure enrollees received needed services. For example, care coordinators worked closely with other county staff to arrange medical and behavioral health services for enrollees. For social services, enrollees were linked to staff in the Department of Social Services. Care coordinators reported frequently accompanying enrollees to appointments and/or arranging for transportation to help ensure enrollees attended needed appointments.

Promote accountability within care coordination team. WPC care coordinators met monthly with counterparts from social services, housing, and behavioral health for a confidential case conference. The Pilot also held monthly meetings to discuss general communication, coordination, and sustainability topics. To facilitate communication, care teams reported use of group text messaging to keep each other apprised of changes to their daily schedule and tasks.

Suggested Citation

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