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

Background

To implement WPC, Napa County Health and Human Services Agency (HHSA) worked most closely with two county agencies (Mental Health Department and the local hospital), one managed care plan, and two community partners.

Eligible enrollees were identified using referrals from various organizations, including Napa's emergency services and housing services providers that were not part of the lead entity's organization (e.g., Emergency Medical Services, Police and Fire Departments). Individuals usually remain enrolled until they are housed, in stable condition, and no longer need WPC services.

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

Exhibit 1: Napa WPC Pilot Overview

Lead Entity		Napa County Health and Human Services Agency (HHSA)	
5-Year Projected Enrollment		800	
Enrollment Strategy		Referrals	
Primary Target Population(s)		Homeless, At-Risk-Of-Homelessness	
11 Partner Organizations			
2 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	6 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, Napa's WPC Pilot focused on reducing homelessness, reducing avoidable hospitalizations, and reducing emergency department use by improving overall beneficiary health, increasing suicide risk assessment, increasing access to permanent housing, and implementing strategies to reduce 30-day all cause readmissions.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a team that varied based on enrollee housing status. Enrollees not yet in the coordinated entry system received mobile engagement services from an outreach team comprised of individuals with experience in social work or the lived experience of homelessness. Enrollees waiting for housing while in the coordinated entry system received housing navigation services, and enrollees that were already housed received tenancy support services from case managers with a variety of backgrounds (e.g., nursing, mental health). The average caseload of care coordinators was 40 enrollees.

Data sharing capabilities to support care coordination. By early 2019, Napa's WPC Pilot was finalizing a data sharing agreement with the local hospital but had executed agreements with all other partners. To facilitate data sharing, Napa implemented a universal consent form among all WPC partner organizations.

As of 2019, the Pilot had not yet implemented an electronic care coordination platform, but was able to use a data warehouse and the Homeless Management Information System (HMIS) to store and collect data on enrollees. Enrollee care plans were also shared with partners via HMIS. However, because not all care coordinators were able to access HMIS and the data warehouse, the Pilot also relied on non-electronic methods of data sharing. Subsequently, planned implementation of a care coordination platform was intended to facilitate electronic information sharing, remote access to data, and real-time notifications of enrollee service utilization.

Standardized organizational protocols to support care coordination. Napa's WPC Pilot included standardized protocols for referrals, monitoring, and follow-up during the early part of 2019. To accomplish this, they developed memorandum of understandings with medical, behavioral health and social services partners to clearly define protocols for referrals, monitoring, and follow-up.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided through contracts with external service providers, including a housing organization and the local hospital. HHSA mainly received funding to provide care coordination services through three per-member-per-month (PMPM) bundles: mobile engagement, coordinated entry services, and tenancy care. The mobile engagement service bundle was mainly for enrollees that were homeless and had yet to be entered into the coordinated entry system. The coordinated entry services bundle was for those individuals that had been entered into the coordinated entry system and included housing navigation to assist the enrollees in becoming housing-ready. The tenancy care bundle was for individuals that were successfully housed. Incentive payments were used to encourage care coordination infrastructure and services, including funds for community outreach and migration of key information into the HMIS.

In the last years of the Pilot, Napa planned to have enhanced care coordination services for the 40 highest acuity WPC enrollees through a contract with the hospital CARE (Case Management; Advocacy; Resource & Referral; and Education) Network.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Napa's WPC Pilot used homeless outreach teams located in one of the contracted services providers and in the Napa Police Department to initiate contact with eligible enrollees. These outreach teams worked to identify and engage individuals experiencing both unsheltered homelessness (i.e., encampments) and sheltered homelessness, performed initial intake assessments, enrolled individuals, and entered the enrollee into the coordinated entry system. The homeless outreach teams had vehicles to assist them with this work. Ongoing communication with

enrollees by the care coordination teams occurred primarily in-person and averaged two to three times per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Napa's WPC Pilot used a variety of need assessment tools to determine enrollees' needs, including the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to determine enrollee's need for coordinated entry services. In addition, Napa used a self-sufficiency matrix at least every six months to evaluate enrollee progress in the program. The Mental Health Department performed additional assessments for individuals with mental health issues.

Care plans for WPC enrollees in Napa included a housing service plan and a housing stability plan. The care plan was a client-centered document, addressing issues such as medical and behavioral health needs, as well as documentation needed by the enrollee to secure housing. The housing stability plan addressed what the enrollee needed to maintain housing and was updated as needed for the client (anywhere from weekly to yearly). The documents were maintained in HMIS and accessible to multiple partners involved in the enrollee's care.

Actively link patients to needed services across sectors. Napa's WPC care coordinators used active referral strategies to refer their enrollees to needed services, including medical, behavioral health, and social services. For medical services, the HHSA formed agreements with the local hospital and clinics to arrange for referrals and co-located a medical provider at the day center and shelter to provide basic medical services onsite. Behavioral health and social service staff were also co-located at the day center and shelter, which allowed care coordinators to easily refer enrollees to services and ensure enrollees received needed services.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Napa's WPC Pilot required meetings and other forms of communication between partners and providers to coordinate care, in part because they did not yet have an electronic care coordination platform. The coordinated entry system held a housing meeting every other week with many of the key WPC service providers to discuss individuals with the highest needs. Additionally, each organization had weekly case management and care coordination meetings to receive updates on enrollee progress and discuss any service needs or challenges faced by the enrollees.

Suggested Citation

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