Health Policy Case Study

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

Background

To implement WPC, Orange's Health Care Agency (HCA) worked most closely with three county partners (Community Resources, Behavioral Health Services, and Housing Authority), a managed care plan (CalOptima) and a range of community partners (e.g., local health clinics, medical centers and social service providers for those experiencing homelessness or mental illness).

To identify eligible enrollees, Orange's WPC Pilot developed lists of individuals that met eligibility criteria based on administrative data from the managed care plan. Additionally, the Pilot received referrals from partners, including Behavioral Health Services (BHS), a local

hospital, and local shelters. Length of enrollment in the Pilot could vary from months to years depending on each individual's needs and motivation. The Pilot did not have a formal graduation process; however, enrollees graduated from the program once they no longer needed WPC services.

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

Exhibit 1: Orange WPC Pilot Overview

Lead Entity	County of Orange, Health Care Agency (HCA)		
5-Year Projected Enrollment	9,303		
Enrollment Strategy	Administrative Data from Managed Care Plan and Referrals		
Primary Target Population(s)	Severe Mental Illness and/or Substance Use Disorder, Homeless		
24 Partner Organizations			
1 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	20 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, Orange's WPC Pilot focused on improving diabetes control rates, and reducing

emergency department utilization, inpatient stays, and all-cause hospital readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a range of different public and private partner organizations. Staff providing care coordination services varied based on enrollees' point of entry into the program, but included social workers, mental health specialists, nurses, licensed vocational nurses and community outreach workers. Several partnering organizations hired staff with lived experience to facilitate enrollee engagement. Staff caseload also varied across organizations and by role, but typically ranged from 10-15 enrollees for BHS mental health specialists and 30-60 enrollees for hospital or local community clinic-based care coordinators.

Data sharing capabilities to support care coordination. As of November 2018, Orange had data sharing agreements in place with all key partner organizations and implemented a single universal consent form to facilitate data-sharing. Orange's WPC Pilot also developed and implemented a new care coordination platform (called WPC Connect). This platform was used by care coordinators to enroll individuals in the program; develop, store, and share care plans with WPC partners; access established contacts and services for enrollee; and send referrals to providers. Behavioral health and social service data were automatically uploaded on a daily basis. Staff could access WPC Connect using phones or tablets in the field, and received real-time notifications when enrollees accessed the emergency department.

Standardized organizational protocols to support care coordination. Orange's WPC Pilot used standardized protocols for referral pathways and referral tracking and follow-up. For example, all WPC providers also used the WPC Behavioral Health Outreach & Engagement team to assess WPC enrollee needs and make behavioral health referrals. All care coordinators were required to submit monthly referral lists and were held accountable by Orange's HCA for ensuring those referrals were tracked and followed-up on.

Financial incentives to promote cross-sector care coordination. Orange's HCA contracted out all care coordination services to external service providers (e.g., county BHS, the hospital, and local clinics). The Pilot's care coordination services were financed by three per-member-per-month (PMPM) bundles: 1) homeless navigation services in the hospital and clinics; 2) supportive and linkage services at drop-in and multi-service centers; and 3) specific outreach & navigation for those with serious mental illness. Enrollees were assigned to a PMPM bundle based on their need and acuity.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Initial outreach and engagement of potential enrollees typically occurred in the field. Once enrolled, ongoing communication between enrollee and care coordination staff typically occurred in-person and/or by telephone. Staff met with each enrollee at least once a month, or more frequently depending on the enrollee's needs.

Conduct needs assessments and develop comprehensive care plans. As of early 2019, needs assessment processes were not standardized and varied across participating organizations. However, care coordinators were all required to develop a single, comprehensive care plan that was accessible to all WPC partners.

Actively link patients to needed services across sectors. Active referral strategies were described as a key component of Orange's WPC Pilot. Care coordinators were able to use the WPC Connect platform to directly refer enrollees to needed medical, behavioral health and social services. For example, when referring enrollees for medical care, care coordinators would help enrollees access or change their primary care provider, coordinate transportation

to appointments, and facilitate access to recuperative care when needed.

Promote accountability within care coordination team. Each partner organization had their own accountability structure. For example, the local shelter held regular meetings with key partners (e.g., county BHS, the managed care plan, public health nurses) to discuss their enrollees and their needs. As of early 2019, care coordinators were not yet accountable for following enrollees across organizational boundaries even though each organization providing care coordination services had their own systems in place to support these activities. However, the pilot noted as part of their oversight that some of the more challenging WPC clients needed more care coordination. and Orange's WPC Pilot was already in the process of developing a new core care coordinator position and concept that would be responsible for serving as the primary point of contact for the length of an enrollee's involvement with the WPC program.

Suggested Citation

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