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

Background

To implement WPC, Placer County Health and Human Services (HHS) worked most closely with other County programs, law enforcement, two managed care plans and community-based organizations.

Eligible enrollees were identified primarily through referrals from partner organizations (e.g., hospitals, managed care plans, probation and law enforcement, and other community partners) and from community outreach to identify individuals who were homeless and/or on probation who might be eligible for WPC services.

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

Exhibit 1: Placer WPC Pilot Overview

Lead Entity	Placer County Health and Human Services (HHS)		
5-Year Projected Enrollment	450		
Enrollment Strategy	Referrals		
Primary Target Population(s)	High Utilizers, Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness, Justice Involved		
20 Partner Organizations			
2 County Health and Mental Health	3 County Housing, Justice, or Social Services	2 Managed Care Plans	13 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, Placer's WPC Pilot focused on increasing housing for the homeless, reducing hospital readmission rates, improving health after medical respite, providing suicide risk assessments, and improving depression remission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a multidisciplinary team with a

range of experience. Enrollees were assigned to a primary care coordinator. This care coordinator could be an individual with lived experience similar to that of the enrollee or an individual with master's level expertise in an area of identified need. Staff were responsible for providing not only care coordination but also case management. Care coordinators were supported by nurses, clinicians, and housing specialists. Average care coordinator caseload was approximately 15 enrollees.

Data sharing capabilities to support care coordination.

By 2019, HHS executed data sharing agreements with some but not all partners. The Pilot used multiple different release-of-information forms to gather consent from enrollees for data sharing.

Care coordinators used two electronic databases. An electronic health record (Avatar) was used to manage enrollee health, behavioral health, and social service data. An electronic system called PreManage was used to track care coordination activities, including the care plan, and provide care coordinators with real-time notifications when enrollees received hospital or emergency department services. Some partners directly accessed information in PreManage while others contacted care coordinators for relevant information. As of early 2019, Placer started moving all tracking activities to Avatar only, but still used PreManage to receive real-time notifications. To help promote a person-centered approach to enrollee engagement, care coordinators were provided with cell phones and laptops that they could take into the field.

Standardized organizational protocols to support care coordination. Placer's WPC Pilot included standardized referral protocols, but did not include standardized protocols for monitoring and following-up on the status of these referrals. 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 provided directly by HHS, rather than through contracts with external service providers. HHS was reimbursed for WPC care coordination services primarily through a per-member-per-month (PMPM) bundle for comprehensive complex care coordination. The Pilot's original plan to provide partners with incentive payments for holding appointment times specifically for WPC enrollees were not found to be necessary due to the effective coordination between WPC and its partners. The Pilot redirected these incentive funds to the provision of services.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Placer's WPC Pilot mainly used in-person communication with enrollees, though enrollees could also be reached by telephone and text message. Care coordinators typically communicated with enrollees at least once per week, but at a minimum once per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, and typically repeated assessments once per year. Validated instruments used as part of the assessment included the Patient Health Questionnaire-9 or PHQ-9 screener for depression and the Columbia Suicide Assessment form. Needs assessments directly informed development of a comprehensive care plan, which were made accessible to partners through the PreManage system.

Actively link patients to needed services across sectors. Placer's WPC care coordinators used active referral strategies to refer their enrollees to needed services. Care coordinators regularly referred enrollees to primary care, behavioral health services, and social services, utilizing a "whatever it takes" approach similar to the principles of Assertive Community Treatment.

Promote accountability within care coordination team. In order to ensure

accountability within the care coordination team, Placer's WPC Pilot required care coordinators to meet in-person on a weekly or bi-weekly basis. Care coordinators also communicated by email and phone. Supervisors met weekly with care coordinators to provide support around crisis management and case consultation.

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