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

Background

Riverside University Health System (RUHS) is a large health system that includes the Riverside Medical Center, a Behavioral Health Department, a Public Health Department, federally qualified health centers, and primary and specialty care clinics.

To implement WPC, RUHS worked most closely with the Riverside County Probation Department, as well as the County Sheriff's Department, County Social Services, managed care plans, and its community-based service providers.

The overall aim of Riverside's Pilot was to support individuals during the transition from correctional institutions to the community.

Thus, eligible enrollees were primarily identified by registered nurses (RNs) who were located on-site at probation offices and screened probationers to evaluate their health, behavioral health, substance use, housing and social needs. These nurses then connected eligible individuals to care managers. Staff also engaged in targeted outreach in the community, for example at probation resource fairs.

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

Exhibit 1: Riverside WPC Pilot Overview

Lead Entity	Riverside University Health System (RUHS)		
5-Year Projected Enrollment	10,018		
Enrollment Strategy	Screening at Probation		
Primary Target Population(s)	Justice-Involved		
15 Partner Organizations			
4 County Health and Mental Health	4 County Housing, Justice, or Social Services	2 Managed Care Plans	5 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, Riverside's WPC Pilot focused on reduction of re-incarceration, reduction of inappropriate ED use, improving blood pressure

and diabetes control, overall beneficiary health, increasing suicide risk assessment and depression remission rates, and increasing individuals successfully housed.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. To identify enrollees for care coordination services, the Pilot placed eight nurses at nine probation offices. Once enrolled in the program, enrollees were linked to a care manager to receive care coordination services. The care team also included specialists in mental health, alcohol and drug dependence, housing and benefit eligibility. Care managers accessed these specialists as enrollees' needs required. In addition, peer support specialists with lived experience similar to the enrolled population were available to encourage enrollee engagement. Average caseload for RN care managers was 70 to 100 enrollees.

Data sharing capabilities to support care coordination. By 2019, RUHS had executed data sharing agreements with all partners. The Pilot used a segmented universal consent that allowed data sharing across partners. However, care plans were not accessible across all partner organizations.

The Pilot used multiple electronic systems to capture information about enrollees. Nurse care managers mainly used Epic, an electronic health record, for daily care coordination activities. Partners providing care in other departments had read-only access to the Epic database. Care coordinators also had read-only access to partner agency databases containing housing and behavioral health records. In order to facilitate care coordination in the field, care coordination staff had remote access to data.

Standardized organizational protocols to support care coordination. The Pilot created standardized protocols for referring enrollees to services and monitoring and following up on the status of referrals. All referrals were tracked for compliance and outcomes. Ongoing information on referral compliance was provided from the

referral agencies (e.g., Behavioral Health Department) to the WPC team. When a client did not follow through with a referral, the RN care manager reached out to the enrollee to assist with barriers. The RN care manager made up to four failed contacts when an enrollee who had not attended their referred appointments.

Financial incentives to promote cross-sector care coordination. RN care managers and their support team were hired by RUHS and provided all care coordination. The Pilot did not contract out care coordination services. Reimbursement of services was through two per-member-per-month (PMPM) bundles for care management and housing support.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Riverside's WPC Pilot used in-person contact at probation offices to initiate outreach and screen eligible enrollees for needs. Ongoing communication occurred primarily by phone, though in-person meetings and other modes such as letters were also used. As appropriate, RN care managers worked with enrollees' probation officers to determine the best way to communicate, which could include reaching enrollees through their friends or families. Care managers were expected to contact enrollees at least once per month.

Conduct needs assessments and develop comprehensive care plans. Screening nurses performed a formal needs assessment at intake that included a homeless screening tool, a substance use disorder questionnaire, a behavioral health questionnaire, and a WPC-specific assessment to assess use of prescription medications, medical conditions, health insurance coverage, food stamps, and other needs. Nurse care managers repeated this core WPC assessment every six months. Assessment results were used to guide warm hand-offs and connections to service providers. Assessment results and care plans were maintained in Epic.

Actively link patients to needed services across sectors. WPC screening RNs used active

referral strategies to refer their enrollees to needed services. For example, screening RNs were actively involved in helping enrollees make initial medical, behavioral health, and social services appointments and as appropriate, used warm hand-offs to connect enrollees to other providers. RN care managers followed-up on appointments made by the screening nurse at intake. Other members of the care team also used active referral strategies. For example, housing outreach workers drove enrollees to appointments.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Riverside's Pilot required regular "huddles" or brief meetings between nurse screeners and staff at the probation department. Members of the care team also communicated about enrollees and care plan objectives using email. There were monthly meetings in both the eastern and western regions of the county that included behavioral health staff, detention staff, RN care managers, housing representatives, law enforcement, Medi-Cal managed care providers, substance use providers, and probation officers.

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