

October 2019

Care Coordination in California's Whole Person Care Pilot Program: City of Sacramento

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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 the City of Sacramento's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, the City of Sacramento worked closely with community-based service providers, including outreach partners, community clinics, and housing organizations, as well as multiple managed care plans and hospital systems. Providers were organized into four service lines based on the primary type of service provided: eligibility and enrollment, outreach and referrals, housing, and "hub" clinical care coordination. Each enrollee was assigned to a Pathways Care Team comprised of an outreach provider, hub provider, and housing provider.

The Pilot aimed to support people who were homeless and who had high utilization of health care services. Eligible enrollees were identified

by direct referrals from partner organizations, and through community outreach at locations such as shelters, encampments, and hospitals.

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

Exhibit 1: Sacramento WPC Pilot Overview

| | | | |
|-------------------------------------|---|----------------------|------------------------------------|
| Lead Entity | City of Sacramento | | |
| 5-Year Projected Enrollment | 3,787 | | |
| Enrollment Strategy | Direct Referrals and Outreach | | |
| Primary Target Population(s) | High Utilizers, Homeless | | |
| 11 Partner Organizations | | | |
| 4 County Health and Mental Health | 1 County Housing, Justice, or Social Services | 7 Managed Care Plans | 16 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 goal of better care and better health, Sacramento's Pilot focused on improving self-reported health status, decreasing inpatient visits, readmissions, and emergency department visits, and increasing the percentage of homeless enrollees who received housing support services.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were

provided primarily by community health workers (CHWs). Outreach CHWs provided ongoing connection to social services and supports and typically had lived experience similar to the enrollee population. In the community clinic “hubs,” clinical care coordinators supported enrollees and licensed clinical staff such as social workers and nurses who were available for more intensive case management. Housing service providers offered other specialized staff to help provide housing support. Caseloads varied by provider organization and with program enrollment; however, caseloads typically ranged from 25 to 75 for housing providers, 50 to 65 in the health care “hubs,” and 60 to 70 for the outreach and referral providers.

Data sharing capabilities to support care coordination. By 2019, the City of Sacramento had executed data sharing agreements with most of its partners. To facilitate data sharing, Sacramento also implemented a universal consent form used by the WPC eligibility and enrollment partner organizations.

Sacramento’s Pilot used Salesforce to host an online “Shared Care Plan Portal” to store and share enrollee care plans and facilitate real-time data sharing of critical enrollee information (e.g., referrals, goals, concerns, acuity level, interventions, etc.). Care coordinators were able to review service referrals in the system daily to guide their work, and accessed the platform remotely while in the field. Medical contacts were not maintained in the platform but instead stored in separate electronic medical record (EMR) systems. Care coordination staff did not receive real-time notifications of ED visits.

Standardized organizational protocols to support care coordination. Sacramento’s Pilot did not include standardized protocols for referring enrollees to needed services. Each partner in Sacramento’s WPC Pilot used their own internal protocol for making referrals based on enrollee needs identified in the care plan. The data system allowed for referral tracking and follow-up, and each provider used their own

internal protocol for monitoring receipt of services.

Financial incentives to promote cross-sector care coordination. The City of Sacramento was reimbursed for WPC care coordination services primarily through three per-member-per-month (PMPM) bundles that paid a set amount per enrollee. The PMPM bundles were for high-intensity care coordination, low-intensity care coordination, and housing support.

The City of Sacramento contracted out all care coordination services to external providers rather than providing them directly. Contracts outlined the Pilot’s expectations for care coordination (e.g., regarding minimum frequency of engagement with enrollees). In addition, incentive payments facilitated adoption and support of WPC policies and procedures and participation in data sharing and reporting activities.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Sacramento’s Pilot used in-person communication to initiate contact with eligible enrollees. For example, staff visited locations such as shelters and campsites. Care coordinators were expected to engage and follow up with enrollees multiple times per month. The City of Sacramento required this frequency of contact in its contracts, and periodically conducted reviews to ensure compliance.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, and an additional assessment at 90 days to determine enrollee acuity level and progress towards graduation. An additional assessment was required for enrollees to graduate. Assessments informed the development of comprehensive care plans. These comprehensive care plans were updated and shared in the Shared Care Plan Portal.

Actively link patients to needed services across sectors. Care coordinators used active

referral strategies to refer their enrollees to needed services. For example, outreach CHWs helped enrollees apply for social services, schedule appointments, arrange transportation for appointments, and retrieve documentation required for services. “Hub” care coordinators supported and monitored referrals to primary care, specialty care, and behavioral health services. Housing care coordinators supported and monitored referrals into various housing programs (e.g., Housing and Urban Development), Continuum of Care housing programs, and the Housing Choice Voucher program).

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Sacramento’s Pilot required weekly huddles to share data and promote learning. Care team staff also communicated with each other by email, and tracked contacts with enrollees in the Shared Care Plan Portal. Staff held case conferences with external providers and partners as needed.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O’Masta B, Pourat N. 2019. *Care Coordination in California’s Whole Person Care Pilot Program: City of Sacramento*. Los Angeles, CA: UCLA Center for Health Policy Research.