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

Background

To implement WPC, San Benito County Health and Human Services Agency (HHSA) worked most closely with the local hospital and their four clinics, and the homeless shelter due to the Pilot's goal of improving health outcomes for people who were homeless.

Eligible enrollees were primarily identified through referrals. Initially, eligible enrollees were also identified through active outreach and engagement efforts.

The overall characteristics of San Benito's Pilot are displayed in Exhibit 1. San Benito's WPC Pilot was a member of the Small County Whole

Person Care Collaborative (SCWPCC), along with Mariposa.¹ Although counties in the collaborative shared some infrastructure and processes, each county's program was distinct.

Exhibit 1: San Benito WPC Pilot Overview

Lead Entity	San Benito County Health and Human Services Agency		
5-Year Projected Enrollment	114		
Enrollment Strategy	Referrals and Active Outreach		
Primary Target Population(s)	High Utilizers, Homeless, At-Risk-Of-Homelessness		
11 Partner Organizations			
3 County Health and Mental Health	3 County Housing, Justice, or Social Services	1 Managed Care Plan	4 Community Partners ²

Notes: ² 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, San Benito's WPC Pilot focused on improving suicide risk assessment rates, housing services, implementing a uniform housing assessment tool, and reducing hospital readmission rates.

¹ Plumas County was initially a member of the collaborative, and subsequently ended their participation in WPC in September 2018.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by social workers who served as the primary point of contact for enrollees. The focus on social work was partly due to limited availability of public health nurses in the county. In 2019, the Pilot considered hiring peer staff with similar lived experience as WPC enrollees in order to encourage enrollee engagement. Average care coordinator caseload was 8 to 10 enrollees.

Data sharing capabilities to support care coordination. By 2018, HHSA executed data sharing agreements with some partners. To facilitate data sharing, San Benito implemented a universal consent form among all WPC partner organizations.

San Benito's Pilot used a single electronic system, called eBHS, to store and share enrollee data. Care coordinators documented all care coordination activities in eBHS, including referrals, engagement activities, utilization, assessments, and the care coordination plan. To help promote a person-centered approach to enrollee engagement, care coordinators were able to access eBHS in the field. The Pilot's ultimate goal was to use eBHS for real-time communication, although in 2019 they were still in the process of building out the functionality of the system. Information in eBHS could be shared with the managed care plan and county staff, but not with other partner organizations.

Standardized organizational protocols to support care coordination. San Benito's Pilot included standardized referral protocols that were updated every six months. The Pilot also included standardized protocols for tracking and monitoring referrals in the eBHS data system.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided directly by San Benito HHSA, and reimbursed primarily through a per-member-per-month (PMPM) bundle for comprehensive care coordination. A second

bundle also funded housing support services and these services were also provided by HHSA staff.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. San Benito's Pilot mainly used in-person communication with enrollees, though enrollees could also be reached by telephone. Care coordinators contacted enrollees at least once a week, and sometimes more often, depending on enrollee needs.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. The Vulnerability Index - Service Prioritization Decision Assistance Tool (VISPDAT) was conducted once per year. The PHQ-9 screening for depression was conducted at intake and at least every six months, or more often if an enrollee had a high score. Additionally, depending on their response to the PHQ-9, some enrollees completed the Columbia Suicide Severity Rating Scale. Staff also administered a strengths assessment, and updated it as enrollees identified new strengths and goals. Assessments informed a single, person-centered care plan that was stored and access across partners on eBHS.

Actively link patients to needed services across sectors. San Benito's WPC care coordinators used active referral strategies to refer their enrollees to needed services. For example, care coordinators helped enrollees identify a primary care provider (PCP), and accompanied enrollees to visits when needed. Care coordinators also helped enrollees apply for financial support and other benefits programs such as CalFresh and Supplemental Security Income, and provided warm hand-offs to other WPC programs if enrollees moved to a different county.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, San Benito's Pilot required care coordinators to participate in regular, weekly meetings. At these

weekly meetings, staff from the hospital, homeless shelter, and managed care plan were invited to attend. Care coordinators were required to track activities in eBHS as a form of accountability.

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