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 Bernardino County’s WPC Pilot using this framework from implementation to March 2019.

**Background**

To implement WPC, Arrowhead Regional Medical Center (ARMC) worked most closely with two managed care plans, two county agencies (Department of Behavioral Health (DBH) and Human Services Department), and two community partners (Information Services and Sheriff’s Department).

San Bernardino’s WPC Pilot identified eligible enrollees using a scoring algorithm based on administrative data from multiple partners (ARMC, County Public Health and Behavioral Health, and the local managed care plans) and intended to identify chronic conditions and high utilization of inpatient, emergency department, Psychiatric, and/or substance use disorder (SUD) treatment. Enrollees could “graduate” from the WPC program upon completing care plan goals and participated in a formal graduation process that included receipt of a letter of recognition.

The overall characteristics of San Bernardino’s WPC Pilot are displayed in Exhibit 1.

**Exhibit 1: San Bernardino WPC Pilot Overview**

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>Arrowhead Regional Medical Center (ARMC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year Projected Enrollment</td>
<td>2,120</td>
</tr>
<tr>
<td>Enrollment Strategy</td>
<td>Identified via administrative data (medical record, DBH)</td>
</tr>
<tr>
<td>Primary Target Population(s)</td>
<td>High Utilizers</td>
</tr>
</tbody>
</table>

19 Partner Organizations

| 2 County Health and Mental Health | 2 County Housing, Justice, or Social Services | 2 Managed Care Plans | 13 Community Partners |

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 health, San Bernardino focused on increasing hypertension and diabetes control rates, improving self-reported health status, increasing...
depression remission and suicide risk assessment rates, improving patient activation scores, and reducing hospital readmission rates.

**Care Coordination Infrastructure**

**Care coordination staffing that meets patient needs.** Care coordination services were provided by ten care coordination teams, each consisting of a patient navigator supported by three specialists (an alcohol and drug counselor, a nurse, and a social worker). Patient navigators typically had experience providing care coordination and sometimes had lived experience similar to that of WPC enrollees, while specialists were selected specifically for their relevant clinical expertise. Additional staff included a WPC manager, utilization technicians, office assistants, and a business systems analyst, who provided additional back-office support to all ten teams. To achieve WPC enrollment goals, each care coordination team aimed to have a caseload of 50 enrollees.

**Data sharing capabilities to support care coordination.** To develop and implement their scoring algorithm, San Bernardino’s Pilot ensured that data sharing agreements were in place with all key partners. The Pilot did not create a universal enrollee consent form, but instead required enrollees to complete separate release of information forms for WPC (included all managed care plans), the Transitional Assistance Department, and the Behavioral Health Agency.

WPC care teams used a population management platform (Forward Health) to access lists of potential enrollees, develop and store care plans, store notes on enrollees’ care needs and services, and access enrollee medical and behavioral health data. Only WPC team members had access to this platform. The platform allowed remote access, which care coordinators accessed through county-provided smart phones and tables. The platform did not provide real-time notifications of enrollee service utilization.

**Standardized organizational protocols to support care coordination.** San Bernardino’s Pilot did not develop standardized protocols for referral pathways, but did develop protocols for referral monitoring and follow-up. Utilization technicians assisted WPC teams in arranging appointments and following up on referrals. Communication between team members and utilization technicians occurred through phone calls, emails, and texts, as well as standardized to-do lists in the care coordination platform.

**Financial incentives to promote cross-sector care coordination.** San Bernardino’s WPC Pilot did not contract out care coordination services. Their care coordination services were funded through a per-member-per-month (PMPM) care coordination bundle and fee-for-service field-based outreach.

**Care Coordination Processes**

**Ensure frequent communication and follow-up to engage enrollees.** Patient navigators were responsible for initial outreach to prospective enrollees. Typically, patient navigators first attempted to call potential enrollees to arrange a home visit, and if unsuccessful, would then attempt in-person contact without an appointment. Ongoing, in-person contact with enrollees was required after enrollment in the program, with care coordination teams expected to see enrollees in-person at least once per month. In addition, they typically contacted enrollees multiple times per month by telephone, e-mail, or text.

**Conduct needs assessments and develop comprehensive care plans.** Patient navigators were responsible for conducting a comprehensive assessment upon initial enrollment, including validated instruments such as the Patient Activation Measure (PAM) and the PHQ-9 for depression. PAM scores were used to measure enrollees’ ability to manage their own care and readiness to graduate from WPC, and was therefore measured every three months. The PHQ-9 was performed at least once per year and always at enrollment and disenrollment or graduation. Based on needs identified, patient navigators referred enrollees to appropriate specialists on the WPC team (e.g.,
nurse, alcohol and drug counselor, and/or social worker) who were then responsible for developing a care plan in his/her area of expertise to share with the overall team.

**Actively link patients to needed services across sectors.** Care coordination teams were purposively designed to include staff with relevant expertise in medical, behavioral health, and social services so that enrollees could be referred “within team.” Team members actively worked with enrollees by meeting them at their homes, in homeless encampments, or anywhere else in the community, that enabled the enrollee to feel comfortable. Through these visits, care coordinators developed tailored care plans, and ensured enrollees received the services that they needed.

**Promote accountability within care coordination team.** San Bernardino’s WPC Pilot used a unique method to ensure accountability for WPC services. Every month, each WPC team met with the WPC Manger for a WPC Accountability Review (WAR) conference. At these conferences, the team and manager discussed every enrollee, including each enrollee’s status, needs, and barriers to service. The whole team was expected to be up-to-date on each client during these meetings. To prepare, the WPC teams met weekly to cover anticipated WAR conference questions so they could be prepared. As an example of how WAR conferences promoted accountability, utilization technicians were typically responsible for referral follow-up, but at the WAR conference, the entire team was expected to know the referral status of their enrollees.

**Suggested Citation**