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

**Background**

To implement WPC, San Diego County’s Health and Human Services Agency (HHSA) worked most closely with other county agencies such as the local Sheriff’s Department, community-based health and social service providers, and multiple managed care plans.

Eligible enrollees were identified by review of administrative data and by referrals from hospitals, behavioral health providers, justice partners, and housing partners in the community. The Pilot found that referrals resulted in better enrollment and engagement than identification of enrollees from administrative data. San Diego’s Pilot was designed to occur in phases: a two-month outreach and engagement phase, followed by stabilization, maintenance, transition, and aftercare. Enrollees were not considered formally enrolled in the Pilot until they entered the stabilization phase. Length of enrollment varied depending on the enrollee’s needs.

The overall characteristics of San Diego’s WPC Pilot called “Whole Person Wellness Pilot” are displayed in Exhibit 1.

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

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>County of San Diego, Health and Human Services Agency (HHSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year Projected Enrollment</td>
<td>800</td>
</tr>
<tr>
<td>Enrollment Strategy</td>
<td>Referrals from Direct Service Partners</td>
</tr>
<tr>
<td>Primary Target Population(s)</td>
<td>High Utilizers, Homeless, At-Risk-Of-Homelessness</td>
</tr>
<tr>
<td>19 Partner Organizations</td>
<td></td>
</tr>
<tr>
<td>2 County Health and Mental Health</td>
<td>4 County Housing, Justice, or Social Services</td>
</tr>
<tr>
<td>7 Managed Care Plan</td>
<td>6 Community Partners¹</td>
</tr>
</tbody>
</table>

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, San Diego’s WPC Pilot focused on reducing jail recidivism, improving suicide risk assessment rates, increasing receipt of
permanent housing, and improving health care utilization through reduced emergency department (ED) visits and inpatient hospital stays and increased primary care physician visits.

**Care Coordination Infrastructure**

**Care coordination staffing that meets patient needs.** Care coordination services were provided by multidisciplinary Service Integration Teams (SITs). SITs consisted of staff from various backgrounds, and typically included a bachelor’s level social worker, a peer support specialist, a licensed clinician, a housing navigator, and a program manager. Either a social worker or a peer support specialist served as the primary point of contact for enrollees. Due to limited availability of clinical staff, some SITs worked closely with partner clinics to access nurse expertise. There were over ten SITs spread throughout the county. Average SIT caseload varied depending on what phase of the program the enrollee was in.

During early phases of outreach and stabilization, average SIT caseloads were approximately 25 enrollees. During later phases of transition and aftercare, average SIT caseloads were approximately 45 enrollees. In 2019, High Acuity Teams were established with caseloads of around 10 enrollees.

**Data sharing capabilities to support care coordination.** By 2019, San Diego County’s HHSA had executed data sharing agreements with all of its partners. Many of these data sharing agreements already existed prior to WPC. The Pilot used multiple different release-of-information forms to gather consent for data sharing from enrollees; however, to facilitate data sharing, the HHSA also implemented a universal consent form for use by internal county systems and the managed care plans.

All key WPC partners used the same electronic system (ConnectWellSD) to track and report on care coordination activities. Linked data available in ConnectWellSD included medical data from mental health services and health plans, social services data from affordable housing agencies, and data from probation. Care coordinators could read and write data in the ConnectWellSD system, including contacts, notes, assessments, and workflow. To help promote a person-centered care approach to enrollee engagement, care coordinators were able to access data on electronic tablets in the field. Care coordinators also received real-time notifications if enrollees visited the ED.

**Standardized organizational protocols to support care coordination.** San Diego’s Pilot did not include standardized protocols for referring enrollees to needed services because partner agencies accepting referrals had different pathways for accessing their services. However, the Pilot did include standardized protocols for monitoring and following up on referrals. Referrals were tracked in the ConnectWellSD system, and contracts with WPC partners required that information be entered within 48 hours of any service, contact, or referral.

**Financial incentives to promote cross-sector care coordination.** San Diego County’s HHSA was reimbursed for WPC care coordination services primarily through per-member-per-month (PMPM) bundles in addition to the fee-for-service outreach and engagement reimbursement. PMPM bundles were defined based on the enrollee’s phase in the program, ranging from stabilization to transition and aftercare. These phases were defined using milestones, such as attaining housing. PMPM payments were higher for earlier phases, and lower for later phases. The HHSA contracted out all care coordination services to external service providers. Contracted partners received incentive payments for timely enrollment and creation of care plans within 30 days of enrollment.

**Care Coordination Processes**

**Ensure frequent communication and follow-up to engage enrollees.** Care coordinators primarily communicated with enrollees in-person and by telephone. Initial outreach and engagement activities lasted for approximately two months, and consisted of approximately six
to seven contacts in the field to build trust and rapport (e.g., by following up with individualized resources). Following formal enrollment in WPC, care coordinators were expected to contact enrollees at least weekly during the early phases of the program, and later on, at least once per month.

**Conduct needs assessments and develop comprehensive care plans.** Care coordinators performed a formal needs assessment when enrollees were ready to transition from the outreach and engagement phase to the stabilization phase. Assessments included the PHQ-9 depression screening, the Columbia Suicide Severity Rating Scale, the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), and an in-house biopsychosocial assessment that asked about housing, income, legal situation, quality of life, substance abuse, support system, and other factors. Needs assessment informed development of a comprehensive care plan maintained in ConnectWellSD and accessible to all key WPC partners.

**Actively link patients to needed services across sectors.** Care coordinators used active referral strategies to refer enrollees to needed services. For example, care coordinators described using a field-based model to help enrollees access walk-in clinics, establish care with a primary care physician, and access behavioral health and social services.

**Promote accountability within care coordination team.** In order to ensure accountability within the care coordination team, San Diego’s Pilot required care coordinators to participate in weekly multidisciplinary case conference meetings. The Pilot also held regular management team meetings through weekly all-staff meetings and daily huddles.

**Suggested citation**