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

Background

To implement WPC, San Francisco Department of Public Health (SFDPH) worked most closely with other county agencies including the San Francisco Department of Homelessness and Supportive Housing, two managed care plans, and three community partners.

Eligible enrollees were identified using administrative data from an integrated multi-agency data system and classified into three groups: severe risk (homeless more than ten years and a high utilizer of emergency care), high risk (homeless more than ten years or a high utilizer of emergency care), and elevated risk (all other homeless adults). In general, WPC services were not identified to the client as components of WPC; rather, they were integrated into the comprehensive system of care in the Health Department and/or the Department of Homelessness and Supportive Housing. Length of enrollment in WPC varied depending on the enrollee's needs.

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

Exhibit 1: San Francisco WPC Pilot Overview

Lead Entity		San Francisco Department of Public Health (SFDPH)	
5-Year Projected Enrollment		22,600	
Enrollment Strategy		Administrative Data	
Primary Target Population(s)		Homeless	
9 Partner Organizations			
1 County Health and Mental Health	3 County Housing, Justice, or Social Services	2 Managed Care Plans	3 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, San Francisco's WPC Pilot focused on efforts to: (1) develop a universal assessment that prioritizes the most vulnerable clients for access to scarce health, social and housing services; (2) create an interagency care response

system that will wrap around those prioritized clients in a human-centered fashion; and (3) develop an interagency data sharing platform to support both of the above.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. The WPC care coordination program was built on the foundation of an existing street medicine and homeless outreach program. Care coordination services were provided by different types of staff depending on acuity of enrollee needs and how the enrollee entered the WPC program. Care coordination teams included paraprofessional health workers with lived experience similar to that of WPC enrollees, a medical director, medical and psychiatric nurses, social workers, and a psychiatrist. Average care coordinator caseload was 20 to 30 enrollees.

Data sharing capabilities to support care coordination. By 2019, SFDPH had executed data sharing agreements with some but not all partners. Data sharing agreements were being finalized with the health plans involved in the Pilot. The Pilot did not develop a WPC-specific consent form, because this was viewed as a barrier to care that was unnecessary from the perspective of privacy laws and would discourage some prospective enrollees from participating.

Core partners utilized the Coordinated Care Management System (CCMS), an integrated database of 15 disconnected health, housing, and benefits databases for people who used services of the County's Public Health and Homeless Services Departments. The CCMS contained summary pages for each individual in the system. Partners used three different electronic health record (EHR) systems to track enrollee data, and these systems linked to the integrated CCMS system. In August 2019, San Francisco's Pilot was planning to transition to the use of a new EHR (Epic). Care coordinators could read and write data in the data systems. The Pilot did not yet have real-time alerts or remote access for care coordinators, but had identified these as future goals.

Standardized organizational protocols to support care coordination. San Francisco's Pilot did not yet include standardized protocols for referring enrollees to needed services, or monitoring and following up on referrals. In 2019, the Pilot was developing an Interagency Prioritization Pathway to help prioritize services for clients with the highest need. As of July 2019, the Pilot planned to adopt the Coordinated Entry assessment tool as the WPC universal assessment tool. From a prioritized list based on the assessment, those with histories of psychoses and substance use disorders (opiate, stimulants, cocaine, and/or alcohol) and high uses of urgent/emergent services would be further prioritized for services.

Financial incentives to promote cross-sector care coordination. Many, but not all, services were provided through contracts with external service providers. SFDPH and contracted partners were reimbursed for WPC care coordination services primarily through a per-member-per-month (PMPM) care coordination bundle that paid a set amount per enrolled person for patients with high needs. Initially, another PMPM bundle funded engagement services at navigation centers and shelters, but this was subsequently converted to fee-for-service payment. In 2019, SF was approved for a High Intensity Care Team PMPM, which would fund an interagency response to San Francisco's most vulnerable adults experiencing homelessness (those with histories of psychoses and substance use disorders, ranked by utilization of urgent/emergent service).

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. San Francisco's Pilot used street and shelter-based outreach to initiate contact with eligible enrollees. Targeted outreach to have clients assessed for priority status was planned to start in September 2019. The majority of ongoing communication occurred via in-person field visits. Care coordinators were expected to contact enrollees at least weekly, except in cases when enrollees could not be found.

Conduct needs assessments and develop comprehensive care plans. Through the use of an universal assessment tool (Coordinated Entry), enrollees were prioritized and assigned a care coordinator. Care coordinators performed a formal needs assessment at intake and assured that service-specific intakes were completed. Assessments were repeated at minimum once per year, but usually quarterly or as enrollee circumstances changed. The Pilot used assessment results to develop a comprehensive interagency care plan that clearly specified who needed to be involved in care, what services were needed, barriers to accessing these services, and processes for achieving enrollee goals. One of the Pilot's goals was to increase the proportion of enrollees with a comprehensive care plan accessible by the entire team within 30 days.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to refer their enrollees to needed services, and in the case of the street medicine teams, directly provided services. Those prioritized through the Coordinated Entry assessment had active engagement plans developed, implemented, and monitored by leadership of the systems of care.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, San Francisco's Pilot required outreach teams to participate in case meetings at least once per month. Team members communicated about clients on an ongoing basis through phone calls, case meetings, and emails.

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