Care Coordination in California’s Whole Person Care Pilot Program: San Joaquin County


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 Joaquin County WPC Pilot using this framework from implementation to March 2019.

Background
To implement WPC, San Joaquin County Health Care Services Agency (HCSA) worked most closely with four county agencies (Behavioral Health Services, Substance Abuse Services, Correctional Health Services, and San Joaquin General Hospital), two managed care plans, and four community partners.

Eligible enrollees were identified using referrals from internal and external partners and lists of eligible individuals provided by the managed care plans.

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

Exhibit 1: San Joaquin WPC Pilot Overview

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>San Joaquin County Health Care Services Agency (HCSA)</th>
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</thead>
<tbody>
<tr>
<td>5-Year Projected Enrollment</td>
<td>2,255</td>
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<tr>
<td>Enrollment Strategy</td>
<td>Referrals and Health Plan Lists</td>
</tr>
<tr>
<td>Primary Target Population(s)</td>
<td>High Utilizers, Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness</td>
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<tr>
<th>14 Partner Organizations</th>
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<tr>
<td>6 County Health and Mental Health</td>
</tr>
<tr>
<td>2 Managed Care Plan</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 health, San Joaquin’s Pilot focused on increasing the number of WPC enrollees included in the local health information exchange, and on improving incarceration rates, diabetes care, suicide risk assessment rates, housing services, and reducing unnecessary emergency department and inpatient utilization.

Care Coordination Infrastructure
Care coordination staffing that meets patient needs. Care coordination services were provided by individuals from three core teams:
Behavioral Health Services (BHS), Community Medical Centers (CMC), and Population Health. The BHS team was part of the county BHS agency and included mental health specialists and mental health outreach workers. The CMC team was based in a local community-based organization, and the Population Health team was embedded within the county hospital and included registered nurses and licensed vocational nurses. Care coordinator caseloads ranged from 15 to 150 enrollees; however, care coordinators were typically only actively engaged with 15-20 enrollees at any given time and only provided initial outreach to any remaining enrollees in their caseload.

Data sharing capabilities to support care coordination. As of early 2019, San Joaquin’s HCSA had data sharing agreements in place with most key partners, except a local private hospital. The Pilot also successfully implemented a single universal consent form used by all key partners, although obtaining consent for data sharing was described as a challenge. San Joaquin’s Pilot implemented a cloud-based system (Box) to allow key partners to access enrollee care plans; sharing of care plans was contingent on having signed consent forms in place and was described as time-consuming for care coordinators.

Care coordinators in San Joaquin’s Pilot also reported using multiple different systems to access data, input care plans, and track care coordination activities, largely due to each organization providing care coordination services having their own internal electronic databases for use. To facilitate care coordination across organizational boundaries, care coordinators could access and update select documents in Box; however, data available in Box were limited, and care coordinators did not commonly access this system while in the field. Additionally, care coordinators did not receive real-time alerts about enrollee service utilization.

Although not yet implemented in early 2019, San Joaquin’s Pilot reported future plans to implement a new system (ActMD) that would contain more comprehensive enrollee data, be accessible while in the field, and provide real-time alerts when enrollees utilized the ED.

Standardized organizational protocols to support care coordination. As of early 2019, San Joaquin’s Pilot did not have standardized protocols in place for referring enrollees to services and/or for monitoring and following up on the status of these referrals. Instead, each organization providing care coordination services had their own systems in place to support these activities.

Financial incentives to promote cross-sector care coordination. San Joaquin HCSA primarily used one per-member-per-month (PMPM) bundle to fund care coordination services, although certain services were funded on a fee-for-service basis. All care coordination services were contracted out to WPC partner organizations rather than provided directly by the HCSA. San Joaquin’s Pilot provided partner organizations with financial incentives to engage in desired WPC activities. Examples included incentive payments for joining and using the San Joaquin Community Health Information Exchange, and for providing patient navigation and patient advocacy (e.g., assisting a patient not fluent in English with processes needed to access care).

Care Coordination Processes
Ensure frequent communication and follow-up to engage enrollees. Once eligible enrollees were identified and a signed consent form was in place, care coordinators would go out in the field to meet with prospective enrollees (e.g., at recuperative care sites, in shelters, and/or at the hospital). Once enrolled in WPC, ongoing communication occurred primarily in-person in the field, but also by telephone. Frequency of contact between care coordinators and enrollees varied depending on enrollees’ stage of involvement in the WPC program (e.g., initial outreach, active engagement, close to graduation). However, in general, care coordinators reported making meaningful contact more than once a month, with care
coordinators attempting contact between two and five times per week.

**Conduct needs assessments and develop comprehensive care plans.** San Joaquin’s Pilot did not standardize needs assessment protocols or care plans, but instead allowed each organization providing care coordination to use their own tools to evaluate enrollee needs. For example, BHS teams administered a suicide risk assessment to all of their enrollees while the CMC teams regularly used the PHQ (Patient Health Questionnaire)-9. Each participating organization also used their own established care plan templates, and uploaded to Box for sharing with other partnering organizations when enrollees provided consent.

**Actively link patients to needed services across sectors.** The Pilot’s goal was to develop infrastructure through WPC that would allow for active referral of enrollees to needed medical, behavioral health, and social services. Care coordinators were provided with contact information for a wide range of service providers to help facilitate warm hand-offs for enrollees.

**Promote accountability within care coordination team.** Care coordinators typically communicated with one another through email, Box, phone calls, and secure text messaging (Qlik). The Pilot did not require care coordinators to participate in regular, cross-disciplinary case conferencing meetings. However, senior and mid-level staff in relevant WPC partner organizations did participate in regular, quarterly meetings to discuss the Pilot, and identify strategies for improving care coordination processes.

**Suggested Citation**