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

Background

To implement WPC, San Mateo County Health System (SMCHS) worked closely with their managed care plan (Health Plan of San Mateo) and a number of community partners to expand existing programs and create a new program, Bridges to Wellness (BTW), for improving integration of primary care and behavioral health services.

Eligible enrollees that were high utilizers and those with chronic conditions were identified using administrative data, in addition to internal and external referrals. Length of time in the WPC Pilot varied based on each enrollee’s progress in achieving agreed-upon goals. Graduation from the Pilot was determined after a clinical assessment of the client’s stability and progress, followed by a warm handoff to an identified care team, often a behavioral health program or primary care.

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

Exhibit 1: San Mateo WPC Pilot Overview

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>San Mateo County Health System (SMCHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year Projected Enrollment</td>
<td>4,141</td>
</tr>
<tr>
<td>Enrollment Strategy</td>
<td>Administrative Data and Referrals</td>
</tr>
<tr>
<td>Primary Target Population(s)</td>
<td>High Utilizers</td>
</tr>
<tr>
<td>7 Partner Organizations</td>
<td></td>
</tr>
<tr>
<td>0 County Health and Mental Health</td>
<td>2 County Housing, Justice, or Social Services</td>
</tr>
</tbody>
</table>

Notes: ¹ The lead entity performs one or more of these functions. 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 health, San Mateo focused on improving diabetes control, reducing emergency department visits, increasing suicide risk assessment rates, increasing successful housing, and reducing readmission rates.
Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Staffing in San Mateo’s Pilot varied by program and by the organization or health division responsible for delivering the service. Generally, the Pilot took the approach of supporting care coordination across divisions so that enrollees experienced less fragmented care. For example, the Pilot added four social workers in ambulatory care clinics to coordinate care for enrollees. In another program, an RN discharge coordinator for jailed enrollees was responsible for coordinating care for all WPC enrollees transitioning back into the community. These enrollees then were handed off to a care navigator. In the Integrated Medical Assisted Treatment Program (IMAT), Behavioral Health and Recovery Services (BHRS) alcohol and drug services had around eight case managers providing care coordination services, each with a caseload of approximately 30 enrollees.

Finally, BTW care coordination services targeted the highest-risk utilizers and were provided by 15 care navigators supported by two social workers, a nurse practitioner, a triage nurse, and a part-time medical director. The care navigators, who had lived experience similar to that of enrollees, and functioned in a community health worker role, were the main contact for WPC enrollees. Care navigators in the BTW program had a caseload of 12 enrollees and, as a result, could provide extremely intensive services.

Data sharing capabilities to support care coordination. In San Mateo, most WPC partners were internal to the health department (e.g., divisions within SMCHS). However, SMCHS did develop data sharing agreements with nearly all external partners except the Human Services Agency. As of 2019, the Pilot did not have a universal consent form. The Pilot also did not have a standardized, comprehensive care plan shared across partners and/or teams.

San Mateo’s Pilot used multiple systems to support daily care coordination activities, including the local health information exchange (HIE) and electronic health record (EHR), but aimed to have a single system in place by 2020-2021. Care coordination teams could not input data into the HIE, but could access data on health, behavioral health and social determinants of health data, and also received real-time notifications when enrollees utilized the emergency department. Some but not all care coordination teams could access the EHR while in the field.

Standardized organizational protocols to support care coordination. San Mateo’s Pilot did not develop standardized protocols for referral pathways and referral monitoring and tracking. While referrals pathways were used by some care coordination teams, they were not standardized across the Pilot. Each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. Care coordination services were a mix of in-house and contracted service providers. In-house care coordination services were primarily funded through two per-member-per-month (PMPM) bundles: BTW and BHRS. Assignment to the BTW and BHRS bundles was not based on enrollee acuity but instead based on point of entry into the system. For care coordination services provided through contracts with external providers, SMCHS used incentive payments to encourage attendance at complex case conferences and participation in staff training on the use of the HIE.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Outreach and engagement in San Mateo’s Pilot occurred in-person and in the field, where care navigators spent most of their time. Once referred for WPC services, care navigators had up to six months to engage and obtain enrollee consent. Once enrolled, care navigators typically continued to meet with enrollees in-person. While care navigators were required to make contact once per month, staff commonly reported multiple contacts per day or week.
Conduct needs assessments and develop comprehensive care plans. In San Mateo’s Pilot, needs assessment processes varied across WPC programs. For most enrollees, a needs assessment was performed after the Pilot received signed consents. Assessments focused on mental health, alcohol and drug treatment, housing, and medical needs and were repeated annually. Because San Mateo’s Pilot did not have a standardized care plan, care navigators reported reviewing several different care plans across different systems.

Actively link patients to needed services across sectors. Care coordination teams all utilized active referral strategies to ensure their enrollees received needed medical, behavioral health, and social services. For example, care navigators met with their enrollees in the field and would coordinate transportation for them to their medical appointments. All care coordination teams also reported assisting enrollees in applying for and maintaining needed benefits.

Promote accountability within care coordination team. Most care navigators were required to complete a daily progress note each time they contacted an enrollee. Across teams, care navigators reported frequently calling and emailing other teams to discuss enrollee needs; however, these activities were informal and the Pilot did not require participation in regular, in-person across team meetings. Within teams, regular weekly, in-person meetings were held. Additionally, progress notes and treatment plans were available to all team members and supervisors to increase accountability within teams.

Suggested Citation