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

Background
To implement WPC, the County of Santa Clara Health System (CSCHS) worked most closely with six county agencies (Public Health, Information Systems, Reentry Services, Behavioral Health, Supportive Housing, and Social Services), one public medical center, one Medi-Cal managed care plan, and eleven community partners.

Santa Clara’s Pilot utilized an opt-in enrollment process and identified eligible enrollees by referral and through lists provided by the Medi-Cal managed care plans, in which administrative data were used to assign potential enrollees a High Utilizer of Multiple Systems (HUMS) score. The length of time that enrollees stayed in the program varied based on need. The Pilot launched a formal graduation process in 2018.

The overall characteristics of Santa Clara’s WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Santa Clara WPC Pilot Overview

| Lead Entity | County of Santa Clara Health System (CSCHS) |
| Enrollmenet Strategy | Referrals and Administrative Lists |
| Primary Target Population(s) | High Utilizers |
| 35 Partner Organizations |
| 7 County Health and Mental Health | 5 County Housing, Justice, or Social Services | 2 Managed Care Plans | 21 Community Partners |

Notes: 1 Previously the Santa Clara Valley Health and Hospital System (SCVHHS) 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 better health, Santa Clara’s WPC Pilot focused on ensuring needs assessments were completed within 60 days of enrollment, increasing supportive housing, improving depression remission rates and suicide risk assessment rates, and reducing all-cause readmission rates.
Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination teams varied based on enrollee needs and the specific organization providing care coordination services. Community health clinics employed Community Health Workers (CHWs), Licensed Clinical Social Workers (LCSWs), and nurses (RN and LVN), while the CSCHS clinics initially employed nurses and LCSWs and later planned to hire CHWs. Many CHWs had lived experience similar to WPC enrollees to help with engagement. Care coordinators did not have a set caseload, but those providing short-term care management and assisting with nursing home transitions typically worked with between 20-50 enrollees at a time, while those providing more intensive mid- and long-term care management services had caseloads of between 10-20 enrollees.

Data sharing capabilities to support care coordination. Santa Clara’s WPC Pilot developed a Trust Community (TC) to facilitate data sharing between WPC partners. As a result of the TC, CSCHS was able to successfully execute data use agreements with all key partners. The Pilot also implemented a universal WPC consent form used by all partners. Care plans were shared with internal partners using a shared electronic health record (EHR) or Epic, and with external partners via secure file transfer.

CSCHS care coordinators were all clinic-based, and typically used Epic’s HealthLink function to support daily care coordination activities. Community health clinics used their own EHR system (e.g. Nextgen) for WPC documentation as well as a WPC Access database to enter services and relevant patient data which were sent via secure file transfer. Periodic data extracts were pulled from partners who used other electronic health records and data systems to support ongoing analysis of the eligible and enrolled population. For CSCHS clinics, with an upgrade to Epic, coordinators received real-time messaging regarding ED and hospital admissions, including Emergency Psychiatric Services (EPS) admissions. The community health clinics were only able to access enrollee’s medical data and did not receive real-time notification of key events such as ED utilization. Because CSCHS care coordinators were clinic-based, they also did not access the system remotely.

Standardized organizational protocols to support care coordination. Santa Clara’s WPC Pilot developed standardized protocols for referring enrollees to services and monitoring referral statuses. For example, the Behavioral Health Call Center was used to arrange all ambulatory behavioral health appointments. All referrals were tracked using tools within Epic, which sent reminders to care coordinators to follow-up on goals or referrals as needed.

Financial incentives to promote cross-sector care coordination. The Pilot’s care coordination services were funded using four different per-member-per-month (PMPM) bundles that reflected differing enrollee needs: short-term care management, mid-term care management, long-term care management and nursing home transitions. Care coordinators working with each enrollee were expected to use their clinical judgement and enrollee goals to determine which bundle enrollees should be assigned to. Bundles were mutually exclusive, but enrollees could move from one bundle to another if needed. Care coordination services were provided both directly by CSCHS and via contracts with external WPC partners. Contracts with external partners included incentive payments that were used to encourage partner participation in the TC and provision of peer navigation services. WPC funds incentivized service providers’ adoption into the TC.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Care coordinators used in-person outreach with potential enrollees. This process usually entailed reviewing daily clinic schedules to identify patients with appointments that were eligible for WPC. Care coordinators regularly used downtime during the
appointment (e.g., after the nurse took patient vitals but before the provider saw the patient) to discuss the WPC program with potential enrollees and provided a handout with more information. Following the doctor’s visits, the care coordinator would then attempt to enroll the individual by having them sign a WPC authorization form. Following enrollment and development of initial goals, communication between the enrollee and care coordinator was primarily telephonic for most clinics. Some of the community health clinics utilized a service model which included not only telephonic and clinic-based care coordination services but also conducted care coordination services in the home and/or in the field.

**Conduct needs assessments and develop comprehensive care plans.** Santa Clara’s Pilot used several different assessment tools. Health assessments conducted at enrollment include questions related to health and social services needs. Starting in November 2018, CSCHS HealthLink system also included a social determinants of health assessment which the Pilot used to better understand the enrollee’s social needs. Care coordinators used all available data (e.g., HUMS score and assessment results) to assign enrollees to PMPM bundles (e.g., short-, mid-, or long-term care management). Starting in November 2018, care coordinators also started using Epic’s Healthy Planet longitudinal care plan to store and share care plans within Epic HealthLink.

**Actively link patients to needed services across sectors.** Care coordinators used active referral strategies to ensure enrollees received needed services. For example, CHWs would arrange or accompany enrollees to health appointments when needed. Care coordinators also worked to develop relationships with treatment staff that would allow for warm-handoffs of enrollees.

**Promote accountability within care coordination team.** Care coordination teams were located within clinics, which allowed for frequent and informal communication between care coordination team members. Accountability for care coordination activities was also tracked in team meetings at the clinic-level and using tools in CSCHS’ EHR.

**Suggested Citation**