Care Coordination in California’s Whole Person Care Pilot Program: Santa Cruz 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 Santa Cruz County WPC Pilot using this framework from implementation to March 2019.

Background
To implement WPC, Santa Cruz County Health Services Agency (HSA) worked most closely with several county agencies (Behavioral Health, Clinics Services, and Public Health Divisions; and Human Services and Probation Departments), the managed care plan, and three community partners.

Santa Cruz’s WPC Pilot utilized an opt-in enrollment model to facilitate engagement. Eligible enrollees were identified via referrals from partner organizations and self-referral. Length of enrollment varied based on enrollee needs and could range from several months to a year. Enrollees were considered “graduated” from Santa Cruz program once they had fully “stepped down” from the Pilot’s service structure, which was based on acuity and intensity. As of early 2019, the Pilot had not yet implemented a formal graduation ceremony but had plans to do so in the future.

The overall characteristics of Santa Cruz’s WPC Pilot, called “Cruz to Health,” are displayed in Exhibit 1.

Exhibit 1: Santa Cruz WPC Pilot Overview

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>County of Santa Cruz, Health Services Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year Projected Enrollment</td>
<td>625</td>
</tr>
<tr>
<td>Enrollment Strategy</td>
<td>Open Referral Process</td>
</tr>
<tr>
<td>Primary Target Population(s)</td>
<td>Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder, High Utilizers, Homeless, At-Risk-Of-Homelessness</td>
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</tbody>
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19 Partner Organizations

| 7 County Health and Mental Health | 1 County Housing, Justice, or Social Services | 1 Managed Care Plan | 10 Community Partners |

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, Santa Cruz’s WPC Pilot focused on reducing utilization of avoidable health services...
among those with complex medical and behavioral health needs by improving 30-day readmission rates, depression remission, and diabetes and hypertension control.

**Care Coordination Infrastructure**

Care coordination staffing that meets patient needs. Care coordination services were provided by multidisciplinary teams led by a case manager supervisor with a social work background. Each team was organized to include diverse specialists (e.g., housing navigators, peer support coaches), while the case manager with social work background served as the primary point of contact for enrollees. In 2019, the Pilot was in the process of hiring a nurse to provide support for enrollees with behavioral health and medical needs through remote monitoring. Average caseload for each case manager was 25 enrollees.

**Data sharing capabilities to support care coordination.** By early 2019, Santa Cruz County’s HSA had established data sharing agreements with all of its partners, primarily because of partners’ pre-WPC involvement in the county’s Health Information Exchange. The Pilot used multiple different release-of-information forms to gather consent for data sharing from enrollees.

By early 2019, Santa Cruz’s WPC Pilot had procured but not yet implemented an electronic case management platform (“Together for Care”). To facilitate data sharing until this platform was fully implemented, the Pilot utilized the electronic health record, Epic, for sharing medical records and Avatar for sharing behavioral health records with internal county partners, and Excel and Access databases to share data with external WPC partners. Case managers were also able to access data using the Health Information Exchange.

To help promote a person-centered approach to enrollee engagement, case managers were able to remotely access data on mobile laptops or other devices in the field. Access to the enrollee care plan was limited to a subset of care team members. As of early 2019, case managers did not receive real-time notifications if enrollees visited the emergency department; however, case managers would receive these notifications once the new electronic case management platform was fully implemented.

**Standardized organizational protocols to support care coordination.** Santa Cruz’s WPC Pilot did not develop standardized protocols for referring enrollees to services or for monitoring and follow-up on the status of these referrals. Each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

**Financial incentives to promote cross-sector care coordination.** Santa Cruz County’s HSA was reimbursed for care coordination services primarily through two per-member-per-month (PMPM) bundles, which were assigned based on enrollee need of behavioral health services and/or clinical medical services. Some care coordination services were provided directly by Santa Cruz County’s HSA and others via contracts with external service providers. Care coordination contracts with external partners included incentive payments for scheduling primary care and behavioral health appointments within a week of discharge from an inpatient stay, jail, or psychiatric hospitalization.

**Care Coordination Processes**

Ensure frequent communication and follow-up to engage enrollees. Case managers were responsible for initiating contact with potential enrollees and scheduling intake meetings with interested individuals. Case managers communicated with enrollees both in-person, in the field, and by telephone. Case managers were expected to contact enrollees on a weekly basis, but reported aiming for daily contact with enrollees actively receiving WPC services.

**Conduct needs assessments and develop comprehensive care plans.** Case managers performed a formal needs assessment at intake, which was then repeated annually or whenever a significant change in the enrollee’s life occurred.
Needs assessment included the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), informal psychosocial assessments and other additional assessments needed to develop a comprehensive care plan with enrollee-driven goals. As of early 2019, care plans were not shared with partners, but the Pilot expected this to change once the new electronic case management platform was implemented.

**Actively link patients to needed services across sectors.** Case managers used active referral strategies to facilitate enrollee access to needed services. For example, case managers were required to make follow-up appointments with providers and were incentivized to schedule follow-up appointments with primary care and behavioral health providers within seven days of enrollee discharge from hospital or correctional facility.

**Promote accountability within care coordination team.** In order to ensure accountability within the care coordination team, Santa Cruz’s WPC Pilot required case managers to participate in weekly in-person one-on-one supervisory meetings, weekly meetings for multidisciplinary teams and specialties (e.g., for all case managers), bi-weekly meetings with leadership, and monthly meetings with the emergency department staff.

**Suggested Citation**