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

### Background

To implement WPC, Shasta County Health and Human Services Agency (HHSA) worked most closely with two county agencies (Adult Services Branch and Regional Services Branch), the managed care plan, and two community partners.

Eligible enrollees were identified using internal (i.e., intra-agency) and external referrals, as well as self-referrals obtained as a result of field-based outreach efforts. Shasta had an opt-in enrollment process, and length of enrollment varied based on enrollee needs. On average, the outreach and engagement period took 100 days, followed by a 200-day period of enrollment in

WPC services. The program was tiered based on acuity level.

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

Exhibit 1: Shasta WPC Pilot Overview

<b>Lead Entity</b>	Shasta County Health and Human Services Agency (HHSA)		
<b>5-Year Projected Enrollment</b>	600		
<b>Enrollment Strategy</b>	Referrals		
<b>Primary Target Population(s)</b>	High Utilizers		
<b>9 Partner Organizations</b>			
1 County Health and Mental Health	1 County Housing, Justice, or Social Services	1 Managed Care Plan	6 Community Partners <sup>1</sup>

Notes: <sup>1</sup> 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, Shasta's WPC Pilot focused on facilitating communication between enrollees and care managers, connecting enrollees to a patient centered medical home, and improving access to housing for enrollees, suicide risk assessment, diabetes control, and depression remission rates.

### Care Coordination Infrastructure

**Care coordination staffing that meets patient needs.** Care coordination services were provided by multidisciplinary teams, which included master's level case managers, nurses located in partner Federally Qualified Health Centers (FQHCs), and a housing case manager who provided social work and benefits support. The average caseload was 20-25 enrollees.

**Data sharing capabilities to support care coordination.** By early 2019, Shasta County HHSA implemented a multiparty, bi-directional release of information which allowed for data sharing between partners. This release of information form was included in enrollee's initial referral packet, and reviewed as part of the opt-in enrollment process.

As of mid-2019, Shasta's WPC Pilot was in the process of developing a SharePoint-based system to support case management activities. As a temporary solution, staff tracked and shared data in an electronic database that included data visualization functions, spreadsheets, critical paper documents, and encrypted emails. As appropriate, paper documents were used for documentation and tracking.

**Standardized organizational protocols to support care coordination.** Shasta's WPC Pilot included standardized protocols and pathways through which the local hospital and county mental health department could refer enrollees to WPC. However, the Pilot did not develop standardized protocols for referring WPC enrollees to needed services, or for monitoring and following 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.** Some but not all care coordination services were contracted out to external partners, rather than provided directly by Shasta County HHSA. In particular, housing case management was provided by HHSA and

medical case management was provided by two health clinics. Shasta County HHSA was reimbursed for care coordination services using two per-member-per-month (PMPM) bundles, one for intensive medical case management and one for housing case management.

Contracts included incentive payments intended to align contractor goals with those of WPC. Example incentives included payments for inputting homeless enrollees' intake information into the Homeless Management Information System (HMIS) and for achieving certain outcomes (e.g., enrollees stayed in housing for at least six months, enrollees had less than two emergency visits in a six-month period).

### Care Coordination Processes

**Ensure frequent communication and follow-up to engage enrollees.** Shasta's WPC Pilot used outreach in the field or on-site at an FQHC clinic to initiate contact with eligible enrollees. Care coordinators subsequently communicated with enrollees in multiple ways, including in-person (most common), by phone, and text message. Expectations for frequency of communication varied by enrollee acuity. Tier 1 (highest need) enrollees received communication at least weekly, Tier 2 enrollees received bi-weekly communication, and Tier 3 (lowest need) enrollees received monthly communication.

**Conduct needs assessments and develop comprehensive care plans.** Care coordinators performed a formal needs assessment at intake. A case manager, a nurse, and a housing manager each conducted their own assessments to inform the care plan. Assessments included a PHQ (Patient Health Questionnaire)-9 screening for depression and a suicide risk assessment tool. Assessments directly informed the acuity level determination and tier placement of enrollees; assessments were conducted annually.

After determining the prospective enrollee was eligible for the program, team members developed the care plan based on the assessments completed. Care plans focused on medical and housing needs, but also addressed

other topics such as budgeting or general life skills. Staff consistently evaluated the care plan on an ongoing basis.

**Actively link patients to needed services across sectors.** Shasta's WPC care coordinators used active referral strategies to refer their enrollees to needed services. For example, case managers often assisted with making appointments and accompanying enrollees to behavioral health, medical services, and social service appointments.

**Promote accountability within care coordination team.** In order to ensure accountability within the care coordination team, Shasta's WPC Pilot required that the care coordination team meet by phone daily and actively reconnect throughout the week when events occurred. The team used fax and encrypted email to share sensitive information. The SharePoint case management platform was planned to support training and share relevant enrollee information amongst the team.

### Suggested Citation

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