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

Background
To implement WPC, Solano County Health and Social Services (SCH&SS) worked most closely with other county agencies, the Medi-Cal managed care plan, and with community partners (e.g., community health clinics, medical centers, and housing and substance use treatment providers).

Eligible enrollees were initially identified using administrative data from the managed care plan, and later expanded to accept referrals from emergency departments, clinics, and other community-based organizations. The Pilot made this change because the time delay in the data meant not all individuals identified as high utilizers on the managed care plan’s list were actually eligible for WPC, and because of difficulty engaging administratively identified enrollees in services.

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

Exhibit 1: Solano WPC Pilot Overview

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>Solano County Health and Social Services (SCH&amp;SS)</th>
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</thead>
<tbody>
<tr>
<td>5-Year Projected Enrollment</td>
<td>250</td>
</tr>
<tr>
<td>Enrollment Strategy</td>
<td>Referrals and Administrative Data</td>
</tr>
<tr>
<td>Primary Target Population(s)</td>
<td>High Utilizers, Severe Mental Illness and/or Substance Use Disorder</td>
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</tbody>
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<tr>
<th>12 Partner Organizations</th>
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<tr>
<td>4 County Health and Mental Health</td>
</tr>
<tr>
<td>1 Managed Care Plan</td>
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</tbody>
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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 better health, Solano’s WPC Pilot focused on increasing screening for depression and suicide, improving housing support services, engaging primary care providers, and reducing avoidable hospital usage.
Care Coordination Infrastructure

**Care coordination staffing that meets patient needs.** Care coordination services were provided by a multidisciplinary team that included a master’s level clinician serving as a program manager, three master’s level social workers, two peer outreach specialists, a housing coordinator, a mental health and substance use disorder specialist, and an employment specialist. The Pilot deliberately included peer outreach specialists with personally lived experiences similar to that of WPC target populations to help improve enrollee engagement. Average care coordinator caseload was approximately 20 enrollees.

**Data sharing capabilities to support care coordination.** By 2019, SCH&SS had executed data sharing agreements with most partners, with a few being finalized, and also implemented a universal consent form that covered all WPC partner organizations.

All key WPC partners utilized the same electronic data system, ETO, which contained case management data and not medical or behavioral health information. ETO was used by the care coordinators to perform all daily care coordination activities. To help promote a person-centered approach to enrollee engagement, care coordinators were able to access ETO remotely, in the field.

**Standardized organizational protocols to support care coordination.** Solano’s Pilot included standardized protocols in its electronic data system for referring enrollees to needed services and monitoring referral status. Care coordinators tracked referrals and placements, and also made lists of action items to aid in monitoring progress and following up.

**Financial incentives to promote cross-sector care coordination.** SCH&SS was reimbursed for WPC care coordination services primarily through a single per-member per-month (PMPM) bundle that paid a set amount per enrolled person for care coordination. The PMPM bundle was designed to not be duplicative of the Medi-Cal targeted case management (TCM) benefit, and focused instead on funding activities such as peer support, multidisciplinary meetings, and field engagement. All care coordination services were provided through contracts with an external service provider.

Care Coordination Processes

**Ensure frequent communication and follow-up to engage enrollees.** Solano’s Pilot used in-person communication to initiate contact with eligible enrollees, often at the hospital or in the community. Enrollees were classified based on levels of acuity, and expected frequency of communication varied accordingly. For example, care coordinators were expected to contact high acuity enrollees on a nearly daily basis while those with lower acuity might only be contacted once per month (though more often if needed).

**Conduct needs assessments and develop comprehensive care plans.** Care coordinators performed a formal needs assessment at intake, and typically repeated assessments at least once per year and more frequently when warranted. Assessments were also repeated before the enrollee could graduate from the program. Instruments used included the PHQ-9 screener for depression, and a biopsychosocial assessment. Care coordinators used the assessments and collaborated with the enrollee and other members of the care team to develop a care plan that was shared with all relevant partners using ETO.

**Actively link patients to needed services across sectors.** Solano’s WPC care coordinators used active referral strategies to refer their enrollees to needed services. Care coordinators assisted clients with making appointments, arranged transportation as needed, and helped clients navigate the referral process.

**Promote accountability within care coordination team.** In order to ensure accountability within the care coordination team, Solano’s Pilot required regularly scheduled meetings among the care coordination team,
supported by the program manager. Care coordinators were typically expected to attend two weekly meetings to discuss their caseloads. Additionally, care team members communicated with one another by phone, text message, and email.

**Suggested Citation**