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

**Background**

To implement WPC, Sonoma Behavioral Health worked most closely with two county agencies (Human Services and Health Services) and Sonoma County’s managed care plan. For WPC, Sonoma established new relationships with six Federally Qualified Health Centers (FQHCs).

Eligible enrollees were identified using referrals, primarily from FQHCs, but also from the county and other community partners. Length of enrollment depended on the individual’s progress in achieving agreed upon goals.

The overall characteristics of Sonoma’s WPC Pilot are displayed in Exhibit 1.
services worker, and peer outreach workers. Case managers had expertise in a wide variety of domains and served as the primary contact for enrollees, but relied on behavioral health clinicians for support and to write 51/50 holds, when needed. Eligibility and social services workers helped facilitate applications and connection to benefits assistance and social service programs as needed. To improve integration of primary care and behavioral health services, WPC care managers were each assigned to one FQHC, and responsible for coordinating activities with a FQHC nurse. As of early 2019, each care manager was assigned a caseload of no more than 15 clients, though Sonoma Behavioral Health considered increasing this number in the future.

Data sharing capabilities to support care coordination. By early 2019, Sonoma Behavioral Health established data use agreements with health plans to validate eligibility and target population criteria. Sonoma’s Pilot also enabled data sharing between many of its partners, including: Community Development Commission (coordinated entry and access to Homeless Management Information System), participating FQHCS, Redwood Community Health Coalition, and a local substance use treatment provider. To facilitate data sharing, Sonoma implemented a universal consent form among many WPC partner organizations. A limited number of partner organizations did not agree to use the WPC universal consent.

Sonoma Behavioral Health utilized two main data sharing platforms to facilitate daily care coordination activities: TAP (cloud based screening tool used by Sonoma staff and FQHCs) and Watson Care Management (data sharing and case management platform). TAP contained all screening assessment and questionnaire data for clients, and was also used to store and share client records, such as consent forms, health records, etc. Watson Care Management was a new, web-based system that went live in 2018. The system was used to house care plans and integrated data from four source systems (Probation, Human Services, Behavioral Health, and Substance Use Disorder). Care coordinators could access this system remotely and update it in real-time. Because community partners utilized different data systems, data sharing with these partners typically occurred through in-person meetings; however, the Pilot expressed interest in ensuring all partners could access Watson Care Management in the future.

Standardized organizational protocols to support care coordination. Sonoma’s Pilot included standard protocols for referring enrollees to needed services, monitoring referral status, and documenting any follow-up. These protocols were drawn from established referral pathways from a previous program (Community Intervention Program).

Financial incentives to promote cross-sector care coordination. Care coordination services were provided both directly by Sonoma Behavioral Health (Behavioral Health, Social, Housing, Substance Use and Financial Services), and via contracts with partners including FQHCs (medical, legal and housing services). Sonoma Behavioral Health was reimbursed for services using one per-member-per-month (PMPM) bundle (Intensive Case Management (ICM), and one fee-for-service (outreach and engagement). Outreach and Engagement services focused on preparing and introducing enrollees to the concept of case management, whereas ICM services entailed actual provision of case management.

When contracting out services to external partners, Sonoma Behavioral Health included incentive payments to align contractor goals with those of WPC. For example, beginning in 2018, incentives were available to FQHCs for 1) the hiring and retention of nursing staff for outreach and engagement and case management activities and 2) reaching pre-specified pay for performance goals.
Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Sonoma’s Pilot used a variety of methods to initiate contact with eligible enrollees. Referrals into the program came from a variety of sources including community based organizations, county agencies, the county jail, and FQHCs. Once a referral was received, a Clinical Health Program Manager reviewed and assigned the referral to a single case manager. Case managers extensively screened potential enrollees and built relationships, trust, and rapport, primarily in the field and to a lesser extent by telephone. Continuing communication with the enrollee occurred largely by phone and in-person, particularly in a clinic. Case managers were required to contact enrollees face-to-face at least once per month. However, in practice, enrollees were contacted more frequently than that by one or more care coordination team members identified in their comprehensive care plan.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Enrollees received a comprehensive needs assessment to determine: 1) Medi-Cal eligibility, 2) homelessness/at risk of homelessness, based on HUD definition, 3) mental health, 4) substance use disorder, 5) chronic conditions, 6) high utilizers of multiple systems (as determined by medical records) and 7) involvement in criminal justice system. Different components of the needs assessment were administered by different case management team members. Results directly informed development of the comprehensive care plan with actionable, client-centered goals. Everyone on the care team had access to the care coordination plan through Watson Care Management; internal partners had read-write capabilities, while external partners had read only access.

Actively link patients to needed services across sectors. Sonoma’s WPC case managers used active referral strategies and referred their enrollees to needed services. Due to small caseloads, case managers often accompanied enrollees to their appointment. Additionally, specialized members of the care team ensured that enrollees applied for all eligible social services. Sonoma’s Pilot also assigned team members to dedicated regions in the county on certain days, to make troubleshooting referrals easier.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, care managers frequently reviewed client goals with their care team and client to ensure progress was being made. The responsible team member was held accountable for ensuring that all referrals were completed and any required follow-up was arranged. Case managers and their teams were responsible for participating in weekly meetings with nurse counterparts at their assigned FQHC, and also engaged in frequent communication through phone and email, as needed. Sonoma’s Pilot found in-person meetings most effective for building relationships needed to effectively coordinate care.

Suggested Citation