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

Background

To implement WPC, the Ventura County Health Care Agency (VCHCA) worked most closely with other county agencies (Behavioral Health Department, Continuum of Care, Human Services Agency, and Medical Center), the Medi-Cal managed care plan, and one community partner (e.g., service providers for individuals experiencing homelessness).

Initially, Ventura's Pilot used administrative data from the Medi-Cal managed care plan to identify potential enrollees and then attempted to contact them by telephone and/or in the field. In addition, the Pilot also employed a referral-based system in which eligible enrollees were primarily identified through referrals from

community partners. This referral-based approach allowed patient engagement closer to the point of care and at a time of established need, resulting in a higher referral completion rate.

The overall characteristics of Ventura's WPC Pilot called "Ventura County Whole Person Care Connect Pilot" are displayed in Exhibit 1.

Exhibit 1: Ventura WPC Pilot Overview

Lead Entity	Ventura County Health Care Agency (VCHCA)		
5-Year Projected Enrollment	2,546		
Enrollment Strategy	Referrals and Administrative Data		
Primary Target Population(s)	High Utilizers		
38 Partner Organizations			
7 County Health and Mental Health	9 County Housing, Justice, or Social Services	1 Managed Care Plan	21 Community Partners ¹

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 goals of better care, timely access and better health, Ventura's Pilot focused on reducing unnecessary emergency room visits and hospital readmissions, improving housing support services, diabetes and hypertension management control, depression remission,

suicide risk assessment and administrative objectives around staff training and service intensity.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a multidisciplinary team tailored to the needs of each client. Multidisciplinary team members included community health workers (CHWs), clinical staff such as nurses, behavioral health practitioners, and addiction specialists. Community Health Workers (CHWs) were the primary point of contact for each enrollee and provided specialized supports such as field-based benefits enrollment and housing support services. The Pilot deliberately included CHWs with lived experiences similar to that of WPC target populations and representative of the communities served to help improve enrollee engagement. Average care coordinator caseload was approximately 60 enrollees, consisting of a mix of higher and lower acuity enrollees.

Data sharing capabilities to support care coordination. By 2019, VCHCA had executed data sharing agreements with some partners. Data sharing agreements and/or internal procedures across affiliated agencies were established to facilitate sharing of health, mental health, and substance abuse treatment information; housing data were handled separately. Ventura's Pilot also implemented a universal consent form to facilitate data sharing across WPC partner organizations.

Care coordinators used multiple databases to support daily care coordination activities, including a Cerner electronic health record (EHR) for medical data, an Avatar data system for behavioral health data, the Homeless Management Information System for housing services data, and an Access database for tracking enrollment information. Ventura's Pilot planned to launch an integrated data system that would unify these sources into a single platform, but had not yet implemented this system as of early 2019.

To help promote a person-centered approach to enrollee engagement, care coordinators were able to access client data on touchscreen laptops and phones with access to WiFi in the field. Care coordinators also received real-time notifications of emergency room and hospital admissions and discharges at Ventura County Medical Center and Santa Paula hospital.

Standardized organizational protocols to support care coordination. Ventura's Pilot included standardized protocols for referring enrollees to needed services. The Pilot used "Lean 6 process mapping" to identify key partners and referral pathways. Ventura's Pilot also included standardized protocols for monitoring and following up on referrals.

Financial incentives to promote cross-sector care coordination. VCHCA was reimbursed for WPC care coordination services primarily through three risk-stratified per-member-per-month (PMPM) bundles: engagement, care coordination, and field-based care coordination. Administrative data and needs assessments informed risk designation and subsequent assignment of enrollees to specific PMPM bundles. Care coordination services were provided directly by VCHCA and through extensive partnerships with collaborative service providers. Incentives encouraged care coordination through payments for developing care plans within 30 days and following up after emergency department visits.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Initial field-based outreach was conducted in the community, either in response to referrals, at specific events or on the street. Once enrolled in WPC, care coordinators communicated with enrollees in-person as well as by phone and text message. Care coordinators were expected to contact enrollees at least once a month by phone, and in person at least once every other month. In practice, frequency of contact varied by enrollee needs and acuity. In particular, enrollees identified as "super utilizers" based on

administrative utilization data were identified and subsequently received more contact.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake and updated every 90 days (central care coordination bundle) and annually thereafter. In addition, all enrollees with a recent emergency department or hospital visit received a weekly comprehensive case review that was made available to care coordinators in the electronic health record. Needs assessments and enrollee input directly informed development of comprehensive care plans and associated goals.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to refer enrollees to needed services. For example, care coordinators could assist with establishing a primary care provider, scheduling appointments, arrange follow-up after hospital visits, help coordinate transportation to appointments, attend appointments with enrollees as their advocate, and assist with applications for housing and employment and benefits programs.

Promote accountability within care coordination team. In order to ensure accountability and collaboration within the care coordination team, Ventura's Pilot team members participated in daily huddles to discuss clients and care plans, and in weekly case conferences led by the WPC program's medical director.

Suggested Citation

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