State of California - Health and Human Services Agency
Department of Health Care Services
Whole Person Care
Lead Entity Narrative Report

Los Angeles County Department of Health Services
Whole Person Care - Los Angeles
Annual Narrative Report, Program Year 5
April 15, 2021

REPORTING CHECKLIST

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	ϒ Completed Narrative report ϒ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	ϒ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	ϒ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.) **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	ϒ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ϒ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	ϒ Completed WPC PDSA report ϒ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	ϒ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

Instructions: Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and, improving health outcomes for the WPC population.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

Section II

I. Increasing Integration among County agencies, Health Plans, Providers, and Other Entities:

Whole Person Care-LA (WPC-LA) continues to build and leverage its relationships with County departments, community stakeholders, health plans, and providers to enhance integration of service delivery models and evaluate and build the capacity of service providers. Given the uncertainty regarding the WPC extension and implementation timeline regarding California's next waiver initiative: California Advancing and Innovating Medi-Cal (CalAIM), WPC-LA program leadership maintained collaborative relationships with health plans, providers, County departments, community stakeholders, and others to help plan for various potential scenarios regarding WPC post – 2020.

The pandemic caused some partnerships to shift, reinforced many existing partnerships and best practices, and facilitated the formation of some new partnerships. In the homelessness arena the Department of Health Services' (DHS') Housing for Health continued to maintain close working relationships with the Office of Diversion and Reentry; the Department of Mental Health; the Department of Public Health; Substance Abuse Prevention and Control; the Department of Public Social Services; the Los Angeles County Development Authority; the Los Angeles Homeless Services Authority; Probation; the Homeless Initiative; the Sheriff's Department; the Housing Authority of the City of Los Angeles; Housing and Community Investment Department; philanthropy; community based agencies; and health providers and plans. These partnerships enabled Housing for Health and the Office of Diversion and Reentry to stand-up Project Room Key sites for high-risk/homeless individuals, Quarantine and Isolation (Q&I) COVID-19 housing for COVID-19 positive or symptomatic homeless individuals, and congregate sites at numerous parks and recreation locations across the County for asymptomatic, non-high-risk homeless clients. COVID-19 response teams provided technical assistance to these

facilities in COVID-19 surveillance testing, infection prevention and control, and system navigation to appropriate interim and permanent supportive housing sites. This integrated system of care response to COVID-19, including bringing in trusted community-based organizations to do targeted outreach and engagement to vulnerable communities in terms of education, system navigation and linkage to COVID-19 testing and supportive programs, such as WPC, facilitated a wrap-around response to the pandemic and maintained referral pathways and access to care for WPC.

During PY 5, the Transitions of Care (TOC) program expanded to Rancho Los Amigos by relying on data instead of hospital referrals, TOC community health workers (CHWs) were able to proactively identify suitable candidates based on a customized TOC screening tool. Collaborations like these between program design and IT enabled TOC referrals to continue during the height of the COVID-19 surge when hospital teams were overwhelmed and couldn't facilitate linkage to the TOC program and CHWs were barred from entering hospitals and had to perform their jobs remotely. Comprehensive Health Accompaniment and Management Platform (CHAMP) enhancements complimented this innovation with the improvements made to referral workflows, specialty screening tools, contactor invoicing, data reporting tools, comprehensive needs assessment, and security and privacy updates. Moreover, improvements to expand the reach of the Los Angeles Network for Enhanced Services (LANES) by enrolling additional health care providers, hospitals, and community clinics from both the public and private sectors in the electronic health information exchange this program year will help to propel LA County's data sharing efforts forward in enhancing health care delivery and service across the County.

II. Increasing Coordination and Appropriate Access to Care/Increasing Access to Housing and Supportive Services:

At the onset of the pandemic in March 2020, when the shelter-in-place orders took effect and hospitals needed to limit traffic through facilities, WPC-LA TOC and Substance Use Disorder (SUD) teams quickly mobilized to make significant changes to their approaches to client engagement, enrollments, and case management. All encounters quickly converted to telephonic encounters, and for many clients already enrolled and established this was a natural transition. A majority of CHWs reported becoming important lifelines to their isolated clients, increasing the frequency and length of their check-in (telephonic) visits.

For other case management activities, CHWs quickly adapted their advocacy and support roles to the phone. The CHWs have been able to provide remote support to help clients apply for CalFresh and other benefits, make PCP appointments, and offer a PCP pre-visit preparation and post-visit debrief. In some cases, CHWs have joined PCP televisits as a three-way call. Other clinical supports were quickly leveraged, such as the TOC Clinical Pharmacists who also converted their post-discharge pharmacy interventions into televists. Our program leadership, training and CHAMP care management teams, along with County Counsel worked tirelessly to adapt workflows, scripts, job aids, and consents

to virtual encounters. All in-person training was converted to virtual learning opportunities and detailed "how to" toolkits were developed to increase the understanding of new workflows and to foster the development of new skillsets for the adapted work.

The County's Housing for Health and Reentry Care Teams in and outside of the jail quickly adapted their practices to address the demands of the pandemic. Resources were mobilized to establish (Q&I) sites for COVID-19 positive at-risk of homelessness and homeless populations. COVID-19 Response Teams were quickly deployed to provide training and technical assistance to street outreach teams and congregate facilities housing homeless, disabled and elderly populations in COVID-19 surveillance testing, infection prevention and control and system navigation. Simultaneously, massive food distribution programs were launched to provide food to 5,000 unsheltered persons daily and 500 permanent supportive housing residents weekly to address increased food insecurity while assisting individuals and families with sheltering in place to help contain the spread of COVID-19.

On the Reentry side, the coordination and launch of post-release reception and admission sites to house individuals released from jail or those recently released from prison where individuals with no place to go could be tested for COVID-19 and housed until their results came back. Clients found to be COVID-19 positive were immediately transferred to Q&I sites to be appropriately cared for, while those awaiting their results underwent housing assessments to see if they were already connected to the Coordinated Entry System and, if not, were entered into the system to facilitate linkage to appropriate housing. The post-release admission and reception center infrastructure was established to quickly address the expedited release of thousands of non-violent inmates from jail to reduce the overall jail census and proliferation of COVID-19 in correctional facilities. In close coordination with the Courts and Sheriff, Reentry Care Teams prioritized inmates daily scheduled for early release and facilitated discharge planning and housing placements. The warm hand-offs to the reception and admission sites greatly aided the post-discharge transition for released inmates, particularly for the medically fragile. Despite the many challenges Los Angeles County faced during the pandemic, WPC-LA program teams mobilized resources, prioritized critical need, adapted the work, and continued to provide essential services to the County's most vulnerable populations.

III. Reducing inappropriate emergency and inpatient utilization/ Improving health outcomes for the WPC population:

Over the course of PY 5, WPC-LA program populations saw significant improvements in decreased hospitalization and emergency department visit rates of -23.9% and -15.8%, respectively, per one thousand Medi-Cal member months six-months after WPC-LA enrollment compared to six-months prior to WPC-LA program enrollment. Some of the notable decreases in hospitalization and emergency department rates occurred for the following programs:

- Countywide Benefits Entitlement Services Team (CBEST): -26.3% reduction in hospital readmissions and -19.8% reduction in emergency department visits;
- Psychiatric Recuperative Care: -71.4% reduction in hospital readmissions and -24.0% reduction in emergency department visits;
- Kin Through Peer: -44.1% reduction in hospital readmissions and -32.0% reduction in emergency department visits; and
- TOC: -47.9% reduction in hospital readmissions and -17.0% reduction in emergency department visits.

During the program year, 13,656 homeless clients were placed into housing. We continued to see very high levels of housing retention rates (98%) for those clients placed in permanent supportive housing and housed longer than six and twelve months, respectively. Despite the challenging circumstances that program teams operated under during the pandemic, we ensured the health and well-being of WPC-LA program clients by achieving the following:

- Proportion of medical high-risk individuals with home visit within 3 business days of discharge 59.6%;
- Proportion of medical high-risk individuals scheduled in primary care within 1 month of discharge 67.7%;
- Proportion of adult justice-involved individuals who receive a 30-day supply of chronic medications in their first month of the program 91.3%; and
- WPC-LA clients served through a medical-legal partnership 684.

IV. Improving data collecting and sharing/ Achieving quality and administrative improvement benchmarks:

In PY5, WPC-LA continued to leverage data sharing efforts to provide care coordination for WPC clients. Because of a noticeable increase in clients who were eligible for both WPC and the Health Homes Program (HHP), we focused efforts on identification of these individuals in order to streamline referral and enrollment workflows. For DHS patients, we enhanced an electronic medical record (EMR) system-generated screening report with a client's HHP status and incorporated it into our CHWs' workflows, asking them to connect the patient back to the primary care medical home if they were already enrolled in or eligible for HHP. As mentioned in the Plan Do Study Acts (PDSAs), we also implemented standardized WPC enrollment and discharge messages in the EMR. These messages were sent to the inpatient and primary care teams for the sake of care coordination and have greatly increased communication and care coordination, particularly during the pandemic when most communications couldn't take place in person.

V. ENROLLMENT AND UTILIZATION DATA

Instructions: For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	**2,066**	**1,701**	**1,535**	**1,081**	**804**	**851**	**8,038**

Revisions of data submitted during Mid-Year report are **bold.*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	944	879	940	927	824	892	13,444

*For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.*

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
FFS1	**667**	**776**	**636**	**233**	-	-	**2,312**
Cost	**$328,237.37**	**$381,877.36**	**$312,981.96**	**$114,661.63**	-	-	**$1,137,758.32**
FFS2	**1,805**	**1,696**	**1,641**	**1,465**	**1,344**	**1,350**	**9,301**
Cost	**$ 406,125.00**	**$ 381,600.00**	**$ 369,225.00**	**$ 329,625.00**	**$ 302,400.00**	**$ 303,750.00**	**$2,092,725.00**
FF3	**3,768**	**3,489**	**3,346**	**3,900**	**4,094**	**3,869**	**22,466**
Cost	**$1,617,941.52**	**$1,498,141.71**	**$1,436,738.94**	**$1,674,621.00**	**$1,757,922.66**	**$1,661,309.91**	**$9,646,675.74**
FF4	-	-	-	-	-	-	-
Cost	$8.00	-	-	-	-	-	-

*Revisions to data submitted during the Mid-Year report are bold.

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
FFS1	-	-	-	-	-	-	2,312
Cost	-	-	-	-	-	-	$ 1,137,758.32
FFS2	821	894	863	824	798	841	14,342
Cost	$184,725.00	$ 201,150.00	$ 194,175.00	$ 185,400.00	$ 179,550.00	$ 189,225.00	$ 3,226,950.00
FFS3	4,056	3,939	3,693	3,469	2,890	2,938	43,451
Cost	$1,741,605.84	$1,691,367.21	$1,585,737.27	$1,489,553.91	$1,240,937.10	$1,261,547.82	$18,657,424.89
FF4	-	-	-	-	-	-	-
Cost	$8.00	-	-	-	-	-	-

*For **Per Member Per Month (PMPM),** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number asreported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed*

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM #1(BA)	Member Months	**636**	**452**	**628**	**149**	**182**	**125**	**2,172**
	$834.86	**$530,971.53**	**$377,357.13**	**$524,292.65**	**$124,394.27**	**$151,944.68**	**$104,357.61**	**$1,813,317.87**
PMPM #2 (HCSS)	Member Months	**11,870**	**12,380**	**12,724**	**13,001**	**13,088**	**13,102**	**76,165**
	$380.17	**$4,512,598.66**	**$4,706,484.54**	**$4,837,262.46**	**$4,942,569.10**	**$4,975,643.75**	**$4,980,966.11**	**$28,955,524.62**
PMPM #3(TSS)	Member Months	**11,870**	**12,380**	**12,724**	**13,001**	**13,088**	**13,102**	**76,165**
	$124.37	**$1,476,301.55**	**$1,539,731.52**	**$1,582,515.66**	**$1,616,966.85**	**$1,627,787.25**	**$1,629,528.47**	**$9,472,831.30**
PMPM #4(Med RC)	Member Months	**287**	**300**	**287**	**256**	**252**	**259**	**1,641**
	$6,153.76	**$1,766,129.14**	**$1,846,128.02**	**$1,766,129.14**	**$1,575,362.57**	**$1,550,747.53**	**$1,593,823.85**	**$10,098,320.25**
PMPM #5 (PsychRC)	Member Months	**156**	**158**	**163**	**172**	**169**	**138**	**956**
	$9,540.21	**$1,488,273.29**	**$1,507,353.72**	**$1,555,054.79**	**$1,640,916.71**	**$1,612,296.07**	**$1,316,549.45**	**$9,120,444.03**
PMPM #6 (Post-Jail)	Member Months	**719**	**675**	**840**	**876**	**580**	**520**	**4,210**
	$408.96	**$294,039.03**	**$276,044.99**	**$343,522.65**	**$358,245.05**	**$237,194.21**	**$212,656.88**	**$1,721,702.81**

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM#7 (Post- Comm)	Member Months	**631**	**663**	**650**	**474**	**360**	**356**	**3,134**
	$820.73	**$517,883.36**	**$544,146.86**	**$533,477.32**	**$389,028.07**	**$295,464.36**	**$292,181.42**	**$2,572,181.39**
PMPM #8 (Post- Extend)	Member Months	**1,098**	**1,089**	**1,042**	**1,179**	**1,253**	**1,288**	**6,949**
	$408.96	**$449,038.08**	**$445,357.44**	**$426,136.32**	**$482,163.84**	**$512,426.88**	**$526,740.48**	**$2,841,863.04**
PMPM #9 (Juvenile)	Member Months	0	0	0	0	0	0	0
	$803.07	-	-	-	-	-	-	-
PMPM #10 (Pre- Release)	Member Months	**507**	**460**	**585**	**594**	**277**	**319**	**2,742**
	$1,628.63	**$825,714.44**	**$749,168.92**	**$952,747.43**	**$967,405.08**	**$451,129.98**	**$519,532.36**	**$4,465,698.21**
PMPM #11(ISR)	Member Months	**349**	**374**	**363**	**298**	**239**	**228**	**1,851**
	$1,102.83	**$384,887.65**	**$412,458.40**	**$400,327.27**	**$328,643.32**	**$263,576.36**	**$251,445.23**	**$2,041,338.23**
PMPM #12 (RBC)	Member Months	**532**	**546**	**507**	**478**	**493**	**410**	**2,966**
	$2,193.88	$1,167,145.05	$1,197,859.39	$1,112,298.01	$1,048,675.44	$1,081,583.66	$899,491.48	$6,507,053.03
PMPM #13(RBC ECC)	Member Months	**15**	**21**	*	**16**	*	*	**75**
	$3,291.06	**$49,365.83**	**$69,112.17**	*	**$52,656.89**	*	*	**$246,829.17**

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM #14 (SUD)	Member Months	**137**	**138**	**152**	111	**99**	**83**	**720**
	$576.54	**$78,986.42**	**$79,562.96**	**$87,634.57**	$63,996.30	**$57,077.78**	**$47,853.09**	**$415,111.12**
PMPM #15 (TOC)	Member Months	**133**	**138**	**151**	**144**	**133**	**119**	**818**
	$452.24	**$60,147.61**	**$62,408.80**	**$68,287.89**	**$65,122.22**	**$60,147.61**	**$53,816.28**	**$369,930.41**
PMPM #16 (KTP)	Member Months	**297**	**262**	**249**	**267**	**272**	**268**	**1,615**
	$1,271,36	**$377,593.92**	**$333,096.32**	**$316,568.64**	**$339,453.12**	**$345,809.92**	**$340,724.48**	**$2,053,246.40**
PMPM #17 (MAMA)	Member Months	**700**	**685**	**685**	**660**	**657**	**704**	**4,091**
	$766.01	**$536,203.51**	**$524,713.44**	**$524,713.44**	**$505,563.31**	**$503,265.30**	**$539,267.53**	**$3,133,726.53**

Revisions of data submitted during Mid-Year report are **bold.*

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
PMPM#1(BA)	Member Months	141	109	183	208	155	259	3,227
	$834.86	$117,715.39	$90,999.84	$152,779.54	$173,651.07	$129,403.44	$216,228.97	$2,694,096.12

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
PMPM#2(HCSS)	Member Months	13,144	13,189	13,221	13,210	13,188	13,406	155,523
	$380.17	$4,996,933.18	$5,014,040.75	$5,026,206.14	$5,022,024.29	$5,013,660.59	$5,096,537.28	$59,124,926.85
PMPM#3(TSS)	Member Months	13,144	13,189	13,221	13,210	13,188	13,406	155,523
	$124.37	$1,634,752.11	$1,640,348.87	$1,644,328.79	$1,642,960.70	$1,640,224.50	$1,667,337.72	$19,342,783.99
PMPM#4(Med RC)	Member Months	242	210	230	229	227	218	2,997
	$6,153.76	$1,489,209.93	$1,292,289.61	$1,415,364.81	$1,409,211.05	$1,396,903.53	$1,341,519.70	$18,442,818.88
PMPM#5 (PsychRC)	Member Months	121	113	110	93	80	70	1,543
	$9,540.21	$1,154,365.82	$1,078,044.12	$1,049,423.48	$887,239.85	$763,217.07	$667,814.95	$14,720,549.32
PMPM#6 (Post-Jail)	Member Months	486	615	609	601	608	753	7,882
	$408.96	$198,752.39	$251,507.65	$249,053.92	$245,782.28	$248,644.96	$307,943.50	$3,223,387.51
PMPM#7 (Post- Comm)	Member Months	419	498	548	506	512	444	6,061
	$820.73	$343,887.69	$408,725.70	$449,762.41	$415,291.57	$420,215.98	$364,406.05	$4,974,470.79
PMPM#8 (Post- Extend)	Member Months	1,273	1,202	1,167	1,097	1,132	1,177	13,997

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
	$408.96	$520,606.08	$491,569.92	$477,256.32	$448,629.12	$462,942.72	$481,345.92	$5,724,213.12
PMPM#9 Juvenile)	Member Months	0	0	0	0	0	0	0
	$803.07	0	0	0	0	0	0	0
PMPM#10 (Pre- Release)	Member Months	318	428	388	369	384	469	5,098
	$1,628.63	$517,903.73	$697,052.82	$631,907.70	$600,963.76	$625,393.19	$763,826.57	$8,302,745.98
PMPM#11(ISR)	Member Months	278	282	253	164	175	185	3,188
	$1,102.83	$306,586.73	$310,998.05	$279,015.98	$180,864.11	$192,995.24	$204,023.53	$3,515,821.87
PMPM#12(RBC)	Member Months	402	329	420	453	368	235	5,173
	$2,193.88	$881,940.43	$721,787.07	$921,430.30	$993,828.40	$807,348.45	$515,562.18	$11,348,949.86
PMPM#13(RBC ECC)	Member Months	*	*	12	*	*	*	119
	$3,291.06	*	*	$39,492.67	*	*	*	$391,635.61
PMPM#14 (SUD)	Member Months	78	84	86	85	74	71	1,198
	$576.54	$44,970.37	$48,429.63	$49,582.72	$49,006.17	$42,664.20	$40,934.56	$690,698.77

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
PMPM#15 (TOC)	Member Months	131	132	144	186	179	177	1,767
	$452.24	$59,243.13	$59,695.37	$65,122.22	$84,116.20	$80,950.54	$80,046.07	$799,103.94
PMPM#16(KTP)	Member Months	246	249	226	268	259	273	3,136
	$1,271,36	$312,754.56	$316,568.64	$287,327.36	$340,724.48	$329,282.24	$347,081.28	$3,986,984.96
PMPM#17 (MAMA)	Member Months	746	740	718	688	697	681	8,361
	$766.01	$571,439.74	$566,843.71	$549,991.60	$527,011.45	$533,905.50	$521,649.40	$6,404,567.93

Please provide additional detail, if any, about your enrollment and utilization for this reporting period. (Optional)

The first table reflects unduplicated NEW enrollees who are enrolled in WPC each month, except for January which indicates how many clients were enrolled (new and continuing) in the first month of 2020.

The costs under the FFS table reflect our actual incurred costs and/or estimated cost depending on the program, for the Medical eligible clients. The costs of uninsured clients are not included.

Due to the impact of COVID-19, FFS 1 (Sobering Center) was converted into a Quarantine and Isolation site for homeless individuals, therefore WPC-LA is not billing for encounters starting in May of 2020.
All numbers that have changed since the Mid-Year Report are indicated by bold font.

VI. NARRATIVE – Administrative Infrastructure

Instructions: Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report. Please limit your responses to 500 words.

Over the program year, WPC-LA maintained staff support for core and essential program operations. Given the uncertainty of WPC-LA's extension until the very end of 2020 and the hiring freeze resulting from the pandemic, hiring for permanent County items remained challenging. WPC-LA experienced staff attrition and employed dual strategies of utilizing existing staff to address staffing shortfalls or contractors to fill critical vacancies to ensure adequate staffing levels.

Over the course of the program year, the following contract positions fulfilled critical administrative and programmatic staffing needs:

Homeless and Housing Support:
- Administrative Assistant I – 7
- Administrative Assistant II – 2
- Assistant Staff Analyst – 3
- Staff Analyst – 3
- Senior Staff Analyst – 1
- Community Health Worker – 14
- Staff Development Specialist – 1

CHAMP Support:
- Senior Information System Analyst - 1
- Staff Analyst – 1
- Staff Development Specialist – 2

Central Administration:
- Accountant II – 1
- DMH program and policy expert – 1

Transitions of Care/Substance Use Disorder:
- Clinical Pharmacist – 6
- Community Health Worker - 7

Despite the hiring freeze and staff attrition, WPC-LA's staffing levels consisted of the following County and contracted staff:

- 9.89 positions for Program Governance;
- 15.39 for IT Infrastructure;
- 49.90 for Program Development and Support; and
- 7.21 for Outreach and Engagement

IV. NARRATIVE – Delivery Infrastructure

Instructions: Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report. Please limit your responses to 500 words.

Further enhancements made to CHAMP in the remainder of PY5 include added functionality to improve contractor invoicing features, update the comprehensive needs assessment tool, and enhance data reporting tools and infrastructure. For a detailed list of additional system enhancements, see below:

1. CR75 Invoice Report & Data Entry (Live in CHAMP 07/15/2020)
2. CR71 Comp Screen (Live in CHAMP 11/13/2020)
3. CHAMP Reports Workspace (Live in CHAMP 11/13/2020)

The improvements made to foundational data collection tools and reporting features in PY5 have improved WPC-LA's ability to conduct comprehensive analyses and reports of program achievements and milestones across program areas and to better understand the characteristics and needs of the populations we serve. Access to data analysis and reporting tools was expanded across program teams enabling staff to view real-time data appropriate to their role, improving service delivery and improving the efficiency and effectiveness of outreach and engagement efforts.

V. NARRATIVE – Incentive Payments

Instructions: Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report. Please limit your responses to 500 words.

During this reporting period, WPC-LA is claiming payment for 45 milestone incentives (inclusive of the Part I and II Budget Adjustment) and one downstream incentive totaling $75,563,000.00 for the PY 5 annual report. Payment to WPC-LA is for work done to achieve the incentives.

Highlights from our achievements for PY 5 include:

- Develop two high-value pharmacy led interventions;
- Train 30 providers in Naloxone use;
- Add functionality in CHAMP;
- Provide LANES support;
- Increase Community Placement Program Bed Capacity;
- Launch 3 post-release reception and admission sites for individuals leaving jail where they are tested for COVID-19 and linked to housing navigation case managers to find interim housing or to Q&I sites for COVID-19 positive cases;
- Develop daily early release lists to prioritize discharge care planning for inmates being released from jails due to COVID-19 precautions;
- Add COVID-19 response teams to provide training and technical assistance to street outreach teams and congregate facilities and congregate facilities that serve persons experiencing homelessness in COVID-19 surveillance testing, infection and prevention control, and system navigation; and
- Develop new community pages for food, housing, immigration, and ACES resources.

VI. NARRATIVE – Pay for Outcome

Instructions: Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology. Please limit your responses to 500 words.

WPC-LA is reporting on all three universal and variant metrics respectively required for the annual report. Please reference the separate Universal and Variant Metrics Template reporting on the data.

During this reporting period, WPC-LA is claiming payment for 25 pay for outcome metrics totaling $43,265,000.00 for the annual report. Payment to WPC-LA is for work done to achieve the respective outcomes.

Some highlights of our achievements this year, include:

- Proportion of clients housed by WPC-LA who are permanently housed for greater than 6 months – exceeded goal of 75% achieving 98.1%;
- Number of homeless WPC-LA clients placed into housing over the course of WPC-LA – exceeded goal of 9,600 clients achieving 13,656;
- Proportion of medical high-risk individuals with pre-discharge hospital visit OR home visit within 3 business days of discharge – exceeded goal of 40% achieving 59.6%;
- 30-day all cause readmissions for medical high-risk individuals – exceeded goal of 2% reduction from baseline by achieving -27.3%;
- Percent decrease in hospitalization rate per 1,000 Medi-Cal Member Months 6 months after enrollment compared to 6 months before to WPC-LA program TOC – exceeded goal of 10% by achieving -47.9%;
- Percent decrease in ED visit rate per 1,000 Medi-Cal Member Months 6 months after enrollment compared to 6 months before to WPC-LA program Psych Recup – exceeded goal of 10% by achieving -24.0%

VII. STAKEHOLDER ENGAGEMENT

Instructions: Please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. An attachment to this report is also acceptable, please note below if this option is being used. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

Please see the attachment titled, "WPCLA_PY5AnnualReport_StakeholderEngagment_Final _ 4.15 .21" for a complete list of our stakeholder engagement activities.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.

1. In response to the transition to teleworking at the onset of the COVID-19 pandemic, TOC and SUD-ENS CHWs have the option to host Zoom video visits with WPC-LA program participants. Each CHW was granted an individual HIPAA-compliant Zoom license. CHWs offer the Zoom video visit option to all enrolled program participants at least once during their time working together. The Zoom video visits have been valuable for both CHWs and program participants to have face-to-face interactions, helping them build rapport. Additionally, CHWs have shared that being able to leverage the screen sharing functionality to demonstrate how to access and navigate online information such as the COVID-19 vaccine appointment site has been very helpful.

2. During PY5, we standardized a documentation process in the County's EMR system to increase communication with the program participants' hospital care team for care coordination purposes. Because the WPC care management platform, CHAMP, is not integrated into the County EMR, these communications were previously happening over secure email or verbally. CHWs started writing standardized WPC Program Enrollment and Program Exit notes/message into the EMR, which has subsequently increased communication between WPC CHWs and medical care team members. These care team members have responded to messages to acknowledge enrollment in WPC, coordinate post-discharge care, learn more about the services provided through WPC, and/or send additional direct referrals to CHWs.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.

1. During the pandemic, we have encountered technological challenges to providing virtual PCP appointment accompaniment. Our CHWs have utilized Zoom calls and phone visits to help clients virtually connect with their providers and/or services. However, most PCP televisits – particularly phone visits – are not optimized for a third member like the CHW to join because: 1) the PCP calls the patient directly; 2) the PCP clinic landlines are not all enabled for 3-way calling; and 3) the PCP may be time-pressed and unable to add another call. As a result of these challenges, our teams have learned to support the client in preparation of their appointment and to follow up after the appointment to assist with any questions. This strategy of support before and after PCP appointments

has helped mitigate some of the challenges when our CHWs have been prevented from attending the actual PCP appointment.

2. In PY5, CHWs in the TOC and SUD programs primarily obtained consent during telephonic engagements with participants. This verbal consent process resulted in most participants having a limited data sharing consent because written consent is required for substance use data sharing. While implementing the verbal consent process enabled us to quickly adapt to remote work and continue serving program participants safely during the COVID-19 pandemic, we were somewhat limited in what care coordination activities we could conduct related to specially protected data types like substance use disorder treatment and services. These limitations especially posed challenges for our CHWs coordinating care for participants in the SUD program, where care coordination activities largely require the exchange of information related to a participant's substance use disorder to connect them with treatment options. To address this challenge, the training team created County Counsel-approved job aids and facilitated virtual refresher trainings for the teams to clarify the specific care coordination activities that would be acceptable with a verbal consent and emphasize the importance of obtaining a signed, written consent from participants when in person engagements are safe to resume.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.

1. In PY 5, WPC-LA continued to enhance our processes for data and information sharing with our hospital partners, with the goal of improving communication and increasing program referrals amidst the limitations imposed by COVID-19. Through sharing and discussing ongoing information about referral volumes, engagement outcomes, and barriers to enrollment, we have collaboratively revised our hospital referral process at one of the participating TOC hospitals. Based on the data, the team developed a process for communicating about every patient engagement through the use of EMR, with the goal of facilitating provider intervention when support for WPC enrollment is needed. The team also developed a more streamlined electronic referral process to the TOC and SUD programs in response to the collective data reviews and discussions, specifically related to improving the timeline for intervention so that we can engage more patients before they leave the hospital. Through this process, a provider can submit a referral electronically through the hospital EMR for either program so that it fits easily into their workflow and can quickly be assigned to a WPC CHW for review.

2. In PY5, the TOC program expanded to an additional high-volume Medi-Cal hospital - the Rancho Los Amigos Rehabilitation Center - by leveraging opportunities for data sharing. The program team has historically encountered challenges with identifying patients potentially eligible for TOC services when relying on direct referrals from hospital staff, and that barrier has only increased with the COVID-19 limitations on hospital staff over the past year. To support the implementation of TOC at Rancho, we collaborated with hospital staff and Information Technology (IT) to develop an independent screening process that leverages an electronic health record (EHR)-based report that was built for other TOC facilities; our Rancho CHWs can proactively identify potentially eligible patients and screen them telephonically prior to engagement – a process that has been critical during the COVID-19 surge. By developing a TOC referral process that relies on available data, rather than referrals from hospital staff, we have been able to implement TOC at Rancho within a timeline and setting that might otherwise have been difficult to achieve.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges**.**

1. The Shared Care Plan is a core tenet of WPC, however it is still challenging to share the Care Plan with most non-WPC providers (primary care providers, hospital teams, some other case managers, etc.) outside of the care management platform, CHAMP, because of: a) ongoing obstacles with data integration outside of our system, and b) a technical issue that the complete Care Plan is comprised of multiple forms in CHAMP that currently cannot be visualized on one page nor exported in a succinct, consolidated manner. However, after many years of planning, we are about to launch a “Summary Care Plan” that can be created at any moment by pressing a button and will become a 1-2 page formatted pdf that can be shared securely outside of CHAMP if in accordance with the client’s consent and data sharing preferences.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.

1. WPC updated the existing Comprehensive Screen Assessment with a more streamlined and standardized workflow to ensure clients' needs are assessed in a systemic, standardized way. The Comprehensive Needs Survey is used as an initial screening tool for WPC clients and is a foundational component of the Care Plan. The electronic version of the Comprehensive Needs Survey in CHAMP was previously underutilized by teams due to its length and cumbersome design, which resulted in client assessment fatigue and difficulty administering the survey. The survey was revised and shortened in PY4 and administered on paper, rather than in CHAMP. In PY5, the in-CHAMP electronic version of the survey was revamped to reflect the changes implemented in the shortened paper version and improve the user interface for easier administration of the survey electronically. Changes to the workflow streamlined data collection, reduced unnecessary steps, and ensured that care plans are created for clients. This update significantly improves the quality of data storage, allowing team members to more easily view survey responses for individual participants in CHAMP and also enables us to store and analyze the data long term, which was previously not possible when the survey was being stored in CHAMP as a scanned paper document.

2. In PY5, a new Reports Workspace was introduced to CHAMP that features several structured reports that all team members can access at any time based on their role. A new report has been created that allows CHWs and Supervisors to track achievement of key program metrics for enrolled clients, along with color-coding to help identify places where data are missing, or goals have or have not been met for a client. This is a significant improvement over previous reporting tools that have only provided a point-in-time historic view of client data. Any changes made to a client's record will be updated in the Reports Workspace immediately. Lastly, a new Data Reports feature has been added that enables program managers to build custom reports.

B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

1. Although CHAMP has been successful in capturing many WPC program metrics, there are challenges we have faced in collecting and reporting on data that provides qualitativeoutcomes of the work that CHWs perform. Our data platform has limitations in reporting qualitative outcome measures that can be instrumental in understanding a client'sengagement with a CHW as well as determining the success of program methods. For example, when it comes to substance use treatment linkage, is it often unclear what typeof substance use treatment a client has accepted, what interventions were used to support the client, and what barriers to treatment exist, all metrics which are helpful in

working in collaboration with community stakeholders and in informing program improvements. We are addressing ways to collect and report out these additional,important outcomes in a more systematic way.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?

The greatest threats to sustaining the legacy and infrastructure built during WPC are related to the combined uncertainty and rapidity of the upcoming CalAIM transition. To provide a few examples, we still do not have concrete details of whether the Enhanced Care Management (ECM) subpopulation inclusion criteria will be more specific, which In Lieu of Services (ILOS) will be offered, what the specific reporting requirements will be, etc. With a lack of necessary information, it is challenging to enact a thoughtful transition plan that will not only be seamless for our clients, but just as importantly, for our large staff. Similarly, it is difficult to make the IT enhancements necessary to enhance the WPC IT infrastructure that we built so that we may leverage it for CalAIM.

IX. PLAN-DO-STUDY-ACT

Instructions: PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

PDSA Attachments:

1. TOC Enroller – Telework Process*
2. Utilizing Express PCP Assignment to Improve PCP Appointment Wait Time*
3. Post-Discharge Follow-Up Calls*
4. ELM Report as Referral Source for Transitions of Care Program*
5. CHAMP Verbal Consents*
6. Capacity Building Team Adaptations to Telework*
7. Improve percentage of Whole Person Care (WPC) Transition of Care (TOC) Enrollees Screened By Clinical Pharmacist(s)*
8. Dashboards for SUD/TOC Programs*
9. Transitions of Care Expansion: Rancho Los Amigos
10. Zoom Video Visits
11. CHAMP Update - Comprehensive Screen
12. ORCHID Documentation: WPC Engagement Outcome Message
13. Reentry Checklist in CHAMP
14. WPC SUD Referrer – HUCLA Substance Abuse Counselor
15. ORCHID Documentation: WPC Enrollment and Program Exit Messages/Notes
16. TOC Enroller – Telework Process #2

*Reported at mid-year period