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

Reporting Checklist

Los Angeles
Annual PY2
4/27/2018

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	☐ Completed Narrative report ☐ 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	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ 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	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ 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	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

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

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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

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.*

Increasing integration among county agencies, health plans, providers and other entities

WPC-LA's programs span our Health Agency, which consists of the Department of Health Services, the Department of Public Health and the Department of Mental Health. We are working closely with other county agencies include the Department of Public Social Services, the Los Angeles Sheriff's Department, Probation, and the County Chief Executive Office. Our local Medi-Cal health plans (LA Care and Health Net) have been involved from the early planning stages and have been key members on our oversight committees. Key community partners, including the LA Regional Reentry Partnership have also been involved in our Principal Partners group and key partners on our Reentry Implementation Team. Since the mid-year, we have continued to build these relationships by continuing our Principle Partners meeting that includes many of these stakeholders. In addition, our team continues to meet with and present WPC opportunities to partners throughout the county in an effort to increase knowledge and awareness of WPC services. In late 2017, we hired a Director of Delivery System Integration and initiated Integration Advisory groups with Health Care Delivery System partners starting with primary care and hospital partners. Our challenges at this stage include ensuring that access to WPC services are made available across the county and resources allocated in a manner that allows all community members who meet criteria to access WPC-LA services they need.

Increasing coordination and appropriate access to care/ Increasing access to housing and supportive services

Since the mid-year report, we have continued to make efforts to create greater integration across the many county systems to open up pathways and increase capacity for services. Buoyed by increased local funding for housing, the County is working at a rapid pace to increase housing stock. In particular, implementation of Measure H, a county-wide sales tax that will provide an estimated $350 million annually to support housing and supportive services, is enhancing capacity to meet the needs of individuals suffering from homelessness in Los Angeles County. However, insufficient housing stock is still a dominant challenge as available permanent

supportive housing and interim housing is not meeting demand even among the highest risk individuals served by WPC-LA.

Greater coordination of housing services across the Health Agency and County departments also represents an opportunity to improve access to housing in the coming years. With increasing funding pouring into housing-related programs across several county departments, there is an opportunity to leverage the Health Agency's Housing for Health program to improve efficiency through greater integration.

Reducing inappropriate emergency and inpatient utilization/improving health outcomes for the WPC population

We now have launched all our WPC programs aside from juvenile justice reentry. All our programs are meant to indirectly reduce costs and utilization on the health system by encouraging and opening access to appropriate utilization, as well as improve health outcomes for each specific target population we have identified. We are beginning to be able to measure the impact of our programs on these outcomes with the submission of our PY2 universal, variant and pay for outcome metrics. We will need to wait on the results of the baseline calculations to begin to evaluate improvements. We plan to track our progress on these key measures of success in real-time whenever possible, and use these data to drive increased value in our programs through our performance improvement program. In the meantime, evaluations of existing Housing for Health programs and preliminary data from our recuperative care programs demonstrate reduce acute care utilization. We are expanding these two programs considerably through WPC-LA and will have the opportunity to evaluate whether we are able to sustain this success with expansion.

Improving data collecting and sharing/achieving quality and administrative improvement benchmarks

In the latter half of performance year 2 our pilot focused on the increased data sharing between WPC and the local health plans for performance reporting and for the universal and variant metrics. We developed a data sharing agreement with the health plans and participating entities. In addition, we defined the data sharing elements for the initial exchanges based on reporting requirements. Because many of our programs started in mid to late 2017, there was not much time during PY2 to make impactful improvements to workflows or quality metrics. With more of a runway in 2018 to make changes, we will have an opportunity to achieve significant improvement in the outcomes that are important indicators of success. Through PY3, we will move from early data sharing successes focused on achieving reporting goals and early markers of success to a wider set of metrics collected by operational teams and data sharing focused on optimizing the potential to impact care delivery and health outcomes for WPC-LA participants.

III. ENROLLMENT AND UTILIZATION DATA

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	3,728	370	491	352	598	871	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	853	1,203	1,200	1,387	1,317	1,382	13,752

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.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	$185,483	$228,046	$341,827	$240,905	$221,269	$314,570	$1,532,100
Utilization 1	0	0	36	67	104	141	348

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	$237,692	$245,876	$338,269	$255,469	$274,526	$309,882	$3,193,813
Utilization 1	119	164	218	228	255	224	1,556

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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 as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed.

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM 1 (BA)	$764.02			$*	$16,808	$126,827	$297,966	$*
	Member months			*	22	166	390	*
PMPM 2 (HCSS)	$514.15	$1,593,872	$1,678,707	$1,812,387	$1,893,108	$1,967,146	$2,047,354	$10,992,574
	Member months	3,100	3,265	3,525	3,682	3,826	3,982	21,380
PMPM 3 (TSS)	$161.66	$501,139	$527,813	$569,844	$595,224	$618,503	$643,722	$3,456,245
	Member months	3,100	3,265	3,525	3,682	3,826	3,982	21,380
PMPM 4 (Med RC)	$5,909.99	$886,499	$1,057,889	$1,176,089	$1,258,828	$1,306,108	$1,270,648	$6,956,061
	Member months	150	179	199	213	221	215	1,177
PMPM 5 (Psych RC)	$10,940.45							
	Member months							
PMPM 6 (Post-jail)	$427.56						$*	$*
	Member months						*	*
PMPM 7 (Post-comm)	$857.70					$*	$ 9,435	$*
	Member months					*	11	*
PMPM 8 (Post-extend)	$427.56							

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	Member months							
PMPM 9 (Juvenile)	$881.94							
	Member months							
PMPM 10 (Pre_	$1,458.52						$*	$*
	Member months						*	*
PMPM 11 (ISR)	$1,030.31						$18,546	$18,546
	Member months						18	18
PMPM 12 (RBC)	$2,139.52	$1,022,690	$1,074,038	$1,144,642	$992,737	$949,946	$911,435	$6,095,488
	Member months	478	502	535	464	444	426	2,849
PMPM 13 (RBC ECC)	$3,044.14	$264,840	$66,971	$82,192	$36,530	$66,971	$106,545	$624,049
	Member months	87	22	27	12	22	35	205
PMPM 14 (SUD)	$615.68					$11,082	$31,400	$42,482
PMPM 14 (SUD)	Member months					18	51	69
PMPM 15 (TOC)	$500.68					$10,014	$20,528	$30,542
	Member months					20	41	61
PMPM 16 (KTP)	$1,246.17							
	Member months							
PMPM 17 (MAMA)	$780.74							
	Member months							

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PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
PMPM 1 (BA)	$764.02	$287,270	$384,300	$480,566	$627,257	$574,540	$681,502	$3,477,801
	Member months	376	503	629	821	752	892	4,552
PMPM 2 (HCSS)	$514.15	$2,153,269	$2,208,284	$2,294,147	$2,374,869	$2,482,841	$2,545,053	$25,051,038
	Member months	4,188	4,295	4,462	4,619	4,829	4,950	48,723
PMPM 3 (TSS)	$161.66	$677,023	$694,320	$721,317	$746,698	$780,646	$800,206	$7,876,456
	Member months	4,188	4,295	4,462	4,619	4,829	4,950	48,723
PMPM 4 (Med RC)	$5,909.99	$644,189	$750,569	$916,049	$963,329	$892,409	$886,499	$12,009,105
	Member months	109	127	155	163	151	150	2,032
PMPM 5 (Psych RC)	$10,940.45	$579,844	$842,415	$984,641	$1,181,569	$1,290,973	$1,170,628	$6,050,070
	Member months	53	77	90	108	118	107	553
PMPM 6 (post-jail)	$427.56	$6,841	$26,936	$57,293	$81,237	$87,222	$113,304	$374,544
	Member months	16	63	134	190	204	265	876
PMPM 7 (post-comm)	857.70	$20,585	$40,312	$54,893	$50,604	$31,735	$51,462	$264,171
	Member months	24	47	64	59	37	60	308
PMPM 8 (Post-extend)	427.56		$*	$5,131	$10,261	$32,067	$62,851	$*
	Member months		*	12	24	75	147	*
PMPM 9 (Juvenile)	881.94							
	Member months							

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PMPM 10 (Pre_	$1,458.52	$17,502	$70,009	$118,140	$107,930	$94,804	$211,485	$625,704
	Member months	12	48	81	74	65	145	429
PMPM 11 (ISR)	$1,030.31	$110,243	$285,396	$368,851	$437,882	$442,003	$374,003	$2,036,923
	Member months	107	277	358	425	429	363	1,977
PMPM 12 (RBC)	$2,139.52	$738,134	$939,249	$975,620	$1,046,225	$883,621	$879,342	$11,557,679
PMPM 12 (RBC)	Member months	345	439	456	489	413	411	5,402
PMPM 13 (RBC ECC)	$3,044.14	$63,927	$130,898	$82,192	$88,280	$112,633	$88,280	$1,190,259
	Member months	21	43	27	29	37	29	391
PMPM 14 (SUD)	$615.68	$49,254	$98,509	$99,740	$115,132	$119,442	$118,211	$642,771
	Member months	80	160	162	187	194	192	1,044
PMPM 15 (TOC)	$500.68	$25,535	$35,548	$43,559	$45,061	$49,568	$51,070	$280,883
	Member months	51	71	87	90	99	102	561
PMPM 16 (KTP)	$1,246.17					$51,093	$89,724	$140,817
	Member months					41	72	113
PMPM 17 (MAMA)	$780.74		$21,861	$34,353	$43,721	$57,775	$72,609	$230,318
	Member months		28	44	56	74	93	295

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

Changes to data from the mid-year report were made in bold.

The costs of the Sobering Center encounters in the FFS section were based on total costs incurred each month as per the revised invoicing guidance.

The first two tables reflect NEW unduplicated enrollees each month.

IV. NARRATIVE – Administrative Infrastructure

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.

Since the mid-year, we continued to hire staff to support the core and essential operations of the WPC team. We brought on:

IV.A. 11 county positions for program governance
IV.B. 12 county positions for IT infrastructure
IV.C. 48 county positions for program development
IV.D. 17 county positions for outreach and engagement

The team members above contributed greatly to the development of our administrative infrastructure to support the delivery of services under Whole Person Care to over 13,000 clients in PY2. As all our programs are built around care management services delivered by community health workers and other allied workforce, it is important that we hired up appropriately to support our frontline staff in day-to-day management as well as core operational and performance improvement infrastructure.

The IT infrastructure funds supported the purchase of computers, tablets, printers, cell phones, telephones, data systems, analytical software, license fees, care management platform, project management services, consultants for data integration, and software for the justice reentry program, among others.

We developed other administrative infrastructure to support recruitment, training and travel for staff at all levels.

V. NARRATIVE – Delivery Infrastructure

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.

WPC-LA programs are numerous and span the entirety of the eight service planning areas in LA County, which covers over 4000 square miles. We successfully identified locations for our eight regional coordinating centers (RCCs) that serve as landing spaces and coordination spaces for our staff to meet and work. These Regional coordination center are in the following regions:

V.A. Lancaster
V.B. Van Nuys
V.C. El Monte
V.D. Boyle Heights
V.E. Hawthorne
V.F. South LA
V.G. Rancho Los Amigos
V.H. Torrance

Each of these RCCs is fully equipped with offices, cubicles, furniture and fixtures and other necessities to ensure that the teams based there can function fully.

In addition, we invested in the development of clinical software delivery infrastructure that is crucial to our pilot's care management abilities. We utilize a customized care management platform called CHAMP, which we continue to improve based on lessons learned from every day use with clients in the community. Delivery infrastructure funds have supported the team and consultants needed to build new interfaces and workflows, improve current workflows and maintain the system every day. Two particular challenges include: 1) building out the security features to enable seamless data sharing and security and 2) ensuring that our housing providers, our benefits advocacy providers and WPC-LA teams work on one unified care management platform. Across these entities, the total number of users on CHAMP is over 1800 individual users.

VI. NARRATIVE – Incentive Payments

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 refer to the invoice for a detailed accounting of all WPC-LA incentive payments and dollar amounts.

Timely Implementation Incentives
We have earned timely implementation incentives for the Homeless, Serious Mental Illness, and Perinatal high-risk populations. For the Homeless High-Risk population, we expanded HCSS and TSS in a timely manner starting (target of November 1, 2017) and started the Psychiatric Recuperative Care Program in July 2017 (target of November 1, 2017). In addition, we added new street teams beginning July 2017 (target of 8 street teams by December 31, 2017). For the Serious Mental Illness High-Risk population, we started enrolling new participants through the Kin Thru Peer program on November 1, 2017 (target of November 1, 2017) with 12 enrollments. For the Perinatal High-Risk population, we started enrolling new participants through MAMA's neighborhood from August 2017 (target of November 1, 2017). Lastly, we contracted and launched WPC-LA's Medical Legal Partnership program (which is available to all WPC-LA participants as an added service) (target of November 1, 2017).

Physical Infrastructure Incentives
We opened 8 Regional Collaborating Centers (RCC's) in each Service Planning Region (SPA) throughout PY2 (target of December 31, 2017). SPAs are specific geographic regions within the County of LA and the designations of the regions are partially used for coordination of care. RCC's within each SPA region are office spaces that are used for Community Health Workers (CHWs), social work supervisors, and regional collaboration leaders, the Associate Directors of Regional Collaboration, to work together.

We added new psychiatric recuperative beds throughout PY2 (target of December 31, 2017). We exceeded our goal of adding 50 new psychiatric recuperative beds in PY2.

IT/Quality Incentives
We launched the final version of CHAMP (Round 1), WPC-LA's Care Management IT Platform. We also developed a monthly WPC-LA quality dashboard that was published in the latter half of the year. A client experience survey was conducted

telephonically across all WPC programs and the report finalized by October 19, 2017 (target of October 15, 2017). We collected and analyzed results as reference for future services to WPC-LA participants. We launched the beta version of CHAMP (Round 2) for our KTP program. We launched the WPC-LA referral access line and call center on July 1, 2017 (target of December 1, 2017). From July 2017 through October 2017, we received 1,332 phone calls in both English and Spanish. Finally, we launched a community resource platform called One Degree (target of December 1, 2017).

All of these incentives are for payments to WPC-LA for work done to achieve the incentives.

VII. NARRATIVE – Pay for Outcome

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.

Pay-for-reporting
WPC-LA plans on reporting all 12 universal and variant metrics at this annual period. Please reference the separate Universal and Variant Metrics report for reported data.

Pay-for-outcome
Please refer to the WPC-LA invoice for a full detail of the pay-for-outcome measures, targets and achievement levels for PY2.

In summary, we have claimed achievement of 20 out of 36 of our pay for outcome measures for PY2.This represents the significant work done by the program teams to ensure quality of care and efficiency of operations to achieve our goals. The outcomes captured in the pay for outcome measures are indicators of improved health and access to care for our target population.

Our successes include:

1. Ensuring that recuperative care clients are linked to permanent housing
2. Submitting applications for disability benefits that are successfully approved
3. Training housing workforce in de-escalation strategies
4. Enrolling clients through our Street Team outreach programs
5. Ensuring that clients are housed with federal vouchers when appropriate
6. Serving clients through our mental evaluation team which represents partnerships with the Sheriff's office
7. Ensuring that clients in the Kin Through peer program receive a visit with 5 business days of referral
8. Ensuring perinatal high-risk individuals receive a care plan within 1 month
9. Producing a WPC sustainability report

Launching our medical-legal partnership program

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, 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. 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.

WPC-LA engages our participating partners and stakeholders on a regular basis. See the table below for a list of our meetings as well as the proceedings since the mid-year report.

**Please limi*

Meeting	Participants	Frequency
Principal partners meeting	**WPC partners and participating entities, including health plans**	**Monthly on Thursdays**
Proceedings: The Principal Partners are invested County departments, health plans, housing authorities and community based organizations that help to inform all major programmatic and funding decisions for Whole Person Care (WPC). The group meets monthly to inform administrative, funding, and policy decisions re: WPC and how best to integrate with other programs and public investments that serve similar safety net populations. **Meeting dates:** July 27, August 24, September 28, October 26, November 30, December 21		
Care design meetings	**WPC partners and participating entities, including health plans**	**Bi-weekly on Wednesdays**
Proceedings: The purpose of these meetings is to convene a group of stakeholders around designing care coordination processes/workflows to maximize the clinical effectiveness of our interventions. They have shaped our enrollment assessment, comprehensive assessment and risk scoring methodology, among other items of critical importance to providing our programmatic interventions. **Meeting dates:** Every other Wednesday		
Evaluation and Learning Team meetings	**WPC partners and participating entities, including health plans**	**Monthly on Wednesdays**
Proceedings:		

The Evaluation and Learning Team is a multi-stakeholder oversight approach to managing evaluation, reporting and performance improvement activities for the WPC-LA committee.

Meeting dates: July 19, August 16, September 20, October 18, November 29, December 13

Team Ops	**WPC partners and participating entities**	**Bi-weekly on Fridays**

Proceedings: The purpose of these meetings is to bring together on a bi-weekly basis the program teams with our health plan partners and other department partners. We discuss programmatic challenges and updates.

Meeting dates: July 14, July 28, August 25, September 8, September 22, October 20, November 17, December 15

LAC/USC + WPC collaboration	**Assistant Chief Clinical Social Worker over LAC USC SW Department and LAC USC Physician for Emergency Department**	**Monthly July 2017 – Dec 2017**

Proceedings: Monthly meetings were scheduled to assist in the collaboration of WPC within the LAC/USC system to support the growth of the TOC and SUD programs in meeting metrics and helping serve the most vulnerable Medi-cal populations of LA County. The purpose of the meetings were to establish guidelines, outline processes to engage clients and refine referral procedures from LAC/USC to WPC.

Meeting dates: 7/18, 8/21, 8/30, 9/27, 11/3, 11/13, 1/17

HFH/WPC Monthly Meeting	**WPC and HFH**	**Monthly**

Proceedings: These monthly meetings create space for executive team members of WPC and HFH to discuss various programmatic, legal, and financial issues that arise during the implementation of WPC. We also update each other on the status of past agenda items, as well as acknowledge goals when we meet them.

Meeting dates: July 14, August 18, October 13, November 17, December 15

Health Consortium of Greater San Gabriel	**Healthcare providers, nonprofit program managers, and**	**One-time**

Valley (HC-SGV) Bi-Monthly Meeting	**representatives of service delivery entities working to improve the healthcare safety net**	
Proceedings: Whole Person Care presented an overview of the program to the HC-SGV to educate healthcare and service delivery professionals as to the services that WPC offers. Three Community Health Workers delivered part of the presentation and fielded questions about the WPC model and their crucial role in the WPC program. **Meeting dates:** September 5		
Camden Coalition Conference Putting Care at the Center	**Whole Person Care Community Health Workers, community health workers from other programs, and 400-500 healthcare providers and nonprofit leaders**	**One-time**
Proceedings: Three Community Health Workers, accompanied by a WPC Improvement Advisor, participated in the 2017 Camden Coalition Conference on complex care. WPC Community Health Workers had the opportunity to meet and work in partnership with health workers and advocates from across the country who work with similar populations, sharing best practices and inviting future collaboration. **Meeting dates:** November 16, November 17		
Harbor UCLA and TOC	**Harbor leadership with WPC TOC**	**Monthly**
Proceedings: To improve TOC and integrate it into hospital operations. **Meeting dates:** September 20, September 28, November 9, December 7		
Data Sharing with Health Plans	**LA Care, Health Net and partnering plans**	**Ad hoc**
Proceedings: LA Care, Health Net and partnering plans have been meeting to develop and implement a data sharing agreement, Business Associate Agreement and Security and Privacy Practices for the Health Plans that would like to share data via the CHAMP platform. The purpose of the meetings has been to develop data sharing agreements that outline the roles and responsibilities of the health plans and DHS relating to all data shared in the CHAMP care management platform to enhance the coordination of care for all WPC and health plan beneficiaries.		

Meeting dates: September 8, October 11, October 27, October 30, October 31, November 1, November 21, December 5, December 11, December 13, December 20, December 26, December 28		
Integration Advisory Board – Primary Care	**WPC, Community Clinics Association of Los Angeles County (CCA-LAC), multiple CCA-LAC members**	**As needed**
Proceedings: Following multiple planning meetings throughout PY2 with CCA-LAC, the Director of Whole Person Care and the WPC-LA Delivery System Integration Team met with multiple representative CCA-LAC member clinics to discuss opportunities for collaboration between community primary care clinics and WPC-LA. We invited representative clinics from all Service Planning Areas, and the two largest Independent practice associations (Health Care Los Angeles, and Altamed) to attend. **Meeting dates:** September 21		
WPC, Hospital Association of Southern California (HASC), multiple HASC members	**WPC, Hospital Association of Southern California (HASC), multiple HASC members**	**WPC, Hospital Association of Southern California (HASC), multiple HASC members**
Proceedings: Following multiple planning meetings throughout PY2 with HASC, the Director of Whole Person Care and the WPC-LA Delivery System Integration Team met with multiple representative HASC hospitals to discuss opportunities for collaboration between hospitals and WPC-LA. HASC organized this workgroup of volunteer hospitals representing various hospital types and LA County regions. **Meeting dates:** October 16		

IX. PROGRAM ACTIVITIES

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

(1) We continue to improve upon the utilization and functionality of the WPC call line, which provides 24/7 access to potential clients as well as resources if they are not WPC-eligible. We have observed an increase in call line volumes since its launch and feel it is a successful access point for our pilot.

(2) Our reentry team continues to improve screening and identification of potential WPC-LA participants in our jails, but the most challenging issue has been ensuring a "warm" hand-off from jail to community at the point of release. The reentry team developed pre-release approaches to improve the handoff to community, including: 1) increasing opportunities for in-reach by community-based care management teams, 2) a telephonic "warm" hand-off between jail-based medical case workers and community-based community health workers, and 3) meetings and team-building events bringing jail-based and community-based staff together for socialization and improved teamwork and communication. We will continue to work on additional interventions through programs funded by our WPC rollover request.

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

(1) Working with a multi-stakeholder group, we designed and implemented a comprehensive assessment into the CHAMP care management platform which is designed to provide a multi-faceted, comprehensive dive into each client's needs. When we developed this assessment, few members of our frontline teams (e.g. social workers, community health workers, medical case workers) were in place. As a result, we were unable to obtain their input. When we finally hired care management staff (Social Worker Supervisors, Community Health workers and Medical Case Workers) to administer the comprehensive assessment, we discovered that completion rates on the comprehensive assessment were low. An 8-step Problem Solving process determined numerous root causes stemming from a lack of engagement around the assessment, including barriers to usability. We will revamp the comprehensive assessment in the coming months to be more acceptable and feasible to our frontline teams. The assessment contains key information for reporting, risk stratification, and care coordination and helps ensure that we are comprehensive in our approach; however, we plan to simplify and hone the assessment to make sure our teams are better able to balance a more comprehensive approach against the need to address a multitude of urgent needs faced by our participants and the short period of time our care teams spend (often < 3 months) with any given WPC participant. A key lesson was the importance of including and seeking input from frontline teams in the program development process.

Now that we have more staff hired, we are able to invite community health workers and other staff into the development and feedback process. As an example, our CHAMP care management platform, now has a User Acceptance Team that tests new modules before releasing it to other teams. This enables us to obtain input prior to building a given CHAMP module and perform iterative user testing and improvement before releasing the module to our broader teams. The User Acceptance team also serves as "superusers" and support training during implementation of a new module.

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

(1) We publish a monthly enrollment dashboard that goes out to all program teams and WPC-LA stakeholders. This dashboard shows several data elements such as monthly enrollments, newly enrolled that month and cumulatively enrolled to date.

(2) The WPC-LA data analytics team successfully defined and planned the parameters for the first major data exchange with the health plans in Los Angeles, LA Care and Health Net. This was after multiple sessions working through the available data on the health plan side and what WPC needs for utilization reporting as well as care management. We have agreed to a final data elements set for our Phase One of data exchange.

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

(1) We continue to manage the barriers in data sharing within our health agency. For example, the Substance Abuse Prevention and Control and the jail systems currently only aggregate metric data based on our WPC enrollee list, due to privacy concerns in sharing client-level sensitive data. We have learned that it is important to support these agencies in understanding the reporting requirements and metric specifications given that they are doing the client-level analysis on their end. We continue to work in close collaboration with our County Counsel to address these barriers and expand knowledge of and opportunities for data sharing.

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

(1) We continue to be successful in expanding the functionality of our new care management platform, CHAMP. CHAMP is our primary data collection system that allows us to track metrics related to care quality. We have developed a short weekly dashboard that shows caseload and care plan completion by CHW or MCW.

(2) We are proud to report all of the universal and variant metric calculations for PY2 during this reporting period. This reflects significant work from multiple stakeholders (agency partners, health plans) as well as nearly full-time effort from our data analytics team.

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

(1) A significant challenge has been confirming Medi-Cal status for some percentage of our served clients due to incomplete data. We must have an accurate social security number and date of birth to be able to confirm active Medi-Cal status to invoice under WPC. With our populations, many individuals do not remember their social security number and sometimes even their date of birth. This makes verification challenging. We are working with our Department of Social Services to improve exchange of information on Medi-Cal status and with our County's Chief Information Officer to leverage a newly developed Countywide Unique identifier to remedy this situation. Full implementation of our data sharing policies and procedures will also help us address some of these barriers.

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

Housing supply continues to be a struggle in the county in the context of decreasing housing affordability. Because housing is so key to eventual health outcomes, WPC-LA is working hard to develop workflows to housing services and available housing units. However, the limited supply of housing will always be a system barrier that is hard to overcome with WPC efforts alone.

Implementation of our WPC programs is fully underway at this point and there are workflows established for many operational areas. A challenge we foresee is being able to tweak and refine those workflows based on lessons learned – the adaptability of our program and workforce and the ability to standardize work and prioritize the highest value activities will be the biggest indicator of success in increasing our enrollments and improving health outcomes. This will be especially challenging in the face of program

growth related to significant staff hiring planned for this year and expanded care delivered by County-contracted community based organizations.

Other barriers include:

1. Continued challenges due to barriers to rapid hiring and onboarding of care management staff

Defining the role of delivery system partners to sustain change after WPC

X. PLAN-DO-STUDY-ACT

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.

Our PDSA attachments are as follows:

Health outcomes: Ambulatory Care – ED Visits

1. Reentry enrollment criteria
2. KTP enrollment criteria

Health outcomes: Inpatient utilization

1. Transitions of Care Utilization Criteria
2. Transitions of Care Case Management

Administrative: Comprehensive care plan

1. Reentry ICHW Waitlist Outreach
2. Supervisor approval of care plans

Administrative: Care coordination and care management

1. CHAMP workflow change – Matched worklist

Administrative: Data and information sharing infrastructure

Enrollment data collection process