Whole Person Care (WPC) Pilot Evaluation Design

The Whole Person Care (WPC) is implemented under the Section 1115 Medicaid Waiver in California called “Medi-Cal 2020”. The program is a 5-year pilot to test county-based initiatives that target high risk high utilizing Medi-Cal beneficiaries, including those with multiple acute and long term care visits, two or more chronic conditions, mental health or substance use disorders, and/or who are homeless or at risk of homelessness. Pilots are to develop the needed administrative and delivery system infrastructure to support provision of high quality coordinated and appropriate care, and improve both process and patient outcomes. These objectives are to improve care delivery, health, and lower costs through reductions in avoidable utilization such as inpatient and emergency department utilization.

Eighteen WPC pilots were approved in the first application round and began operation on January 1, 2017. Seven additional pilots were approved in the second application round and will begin operation on July 1, 2017. Eight of the first round pilots also expanded their pilots in the second application round. The majority have chosen to target beneficiaries with multiple acute visits and those that are homeless or at risk of homelessness. Less than half explicitly focus on beneficiaries with mental health and/or substance use disorders and recently institutionalized populations. There is also variation in care coordination strategies; however, most pilots have chosen to develop a navigation infrastructure, standardize assessment tools being used by participating entities, and expand or develop new data sharing systems. Enrolled beneficiaries have to opt-in and can opt-out at will.

The WPC Pilot Evaluation will assess: 1) if the pilots successfully implemented their planned strategies and improved care delivery, 2) whether these strategies resulted in better care and better health, and 3) whether better care and health resulted in lower costs through reductions in avoidable utilization.

The evaluation design and research questions are based on the Medi-Cal 2020 Demonstration Special Terms and Conditions (STC) Pilot goals, which include:

- Increase integration among county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term;
- Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
- Reduce inappropriate emergency and inpatient utilization;

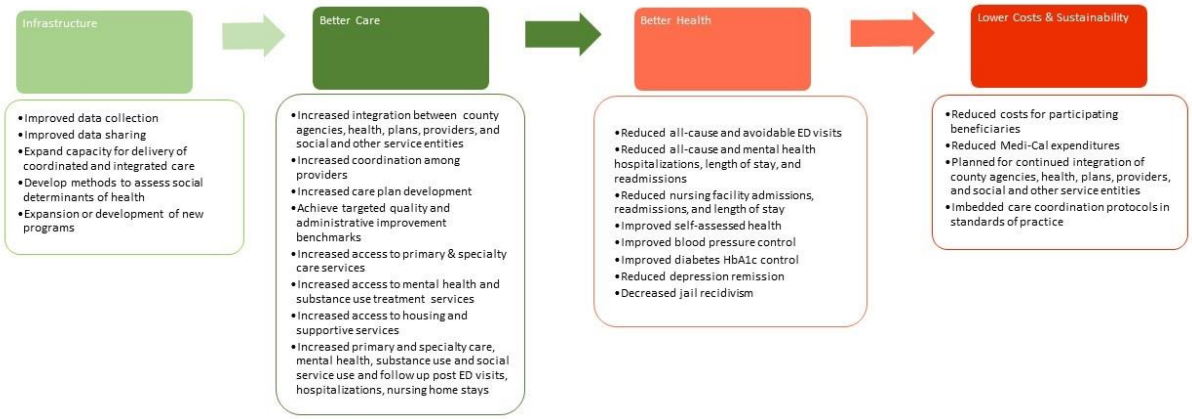
- Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
- Achieve targeted quality and administrative improvement benchmarks;
- Increase access to housing and supportive services (optional); and
- Improve health outcomes for the WPC population.

The evaluation will be completed in compliance with all requirements in the Medi-Cal 2020 Demonstration STCs 112, 123, and 213; STC Attachment GG "WPC Reporting and Evaluation;" and STC Attachment MM "Whole Person Care Requirement and Metrics. In accordance with STC 213, the evaluation will meet standards of leading academic institutions and academic peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

Preliminary Evaluation Framework

WPC evaluation will be based on the preliminary framework displayed in Exhibit 1. The framework incorporates the overarching goals of WPC, program interventions and outcomes. The framework highlights how the program is expected to improve service delivery (better care) and health outcomes (better health), and enhance sustainability of infrastructure improvements and program interventions and reduce costs through reductions in avoidable utilization.

Exhibit 1. WPC Evaluation Conceptual Framework



The evaluation will assess how the pilots achieved the goals of the program through development of infrastructure, delivery of better care, improvements in population health, cost reduction and sustained the practices that led to these outcomes. The delivery of infrastructures is expected to contribute to delivery of better care, which in turn is anticipated to lead to improved population health outcomes. Better care delivery and improved population health are anticipated to lead to reduced costs or improved efficiencies, which would also contribute to sustainability of practices established under WPC pilots in counties and collaborative organizations. The conceptual framework in Exhibit 1 identifies the specific aspects of how the pilots achieved the evaluation goals.

For example, the evaluator will examine whether the pilots developed the needed infrastructure such as data collection and data sharing tools, expanded the capacity for coordinating and integrating care, and the methodology to assess social determinants of health. To assess the delivery of better care, the evaluator will examine the improvements in process of care delivery such as increased integration between pilot entities and increased coordination between providers. Increases in a number of services such as more primary and specialty care visits, mental health and substance use treatment visits, and increased access to housing and supporting services will be used as measures of better care.

The improvements in health of the population (better health) will be measured using two types of measures. One set would include increased rates of the population with outcomes such as controlled blood pressure and diabetes HbA1c control. The other set of measures include reductions in acute and potentially avoidable services such as emergency department (ED) visits or readmissions.

Lower costs would be measured by assessing the costs for targeted beneficiaries as well as a subsequent reduction in Medi-Cal expenditures overall. Sustainability would be measured by the degree to which pilots embedded care coordination activities and integration across pilot entities and their stated plans in continuing these activities after WPC pilots have ended.

Evaluation Data Sources and Measures

Data sources for the evaluation will include WPC pilot applications, mid-year and annual progress reports, quarterly pilot enrollment and WPC service utilization reports, and Medi-Cal enrollment, claims, and encounter data. These data will be supplemented with a structured questionnaire of each WPC Pilot leadership team followed up with key informant interviews. Structured questionnaires and interviews will gather information on multiple domains not systematically addressed in pilot reports, e.g., changes in interagency collaboration and in partners' overall collaborative capacity, synergies with other concurrent programs, alignment with each partner's strategic priorities, program fit with existing work processes in each participating entity, unintended consequences, relevant implementation processes, etc. The questionnaire will be completed by pilots using an online instrument such as SurveyMonkey that allows multiple participants that are most knowledgeable about specific strategies to respond to appropriate questions.

The interviews will follow the questionnaire and will include individuals from pilots who are most knowledgeable about the pilot implementation process and successes and challenges faced to date. It is expected that pilots will vary in how many individuals can provide the necessary information required by the evaluation, and pilots will identify those individuals to participate in the interview. A second set of questionnaires will be completed near the end of WPC by pilots focusing on assessing the sustainability of the pilot strategies. This questionnaire may also be used to address gaps in the information on implementation of pilots gathered in the first round of data collection.

Additional key informant interviews with DHCS staff, Medi-Cal managed care health plans participating in pilots, and other pilot entity participants may be conducted to gain a better understanding of the challenges and successes of the implementation of pilots and to contextualize the quantitative analyses.

The WPC self-reported data, such as mid-year and annual progress reports and quarterly pilot enrollment and service utilization reports, will provide information on pilot infrastructure, approaches to care coordination, data and information sharing infrastructure, services and interventions including housing services (as applicable), physical and behavioral health outcomes, Plan-Do-Study-Act (PDSA) efforts, and lessons learned.

The Medi-Cal enrollment, encounter, and claims data will include data prior to (baseline) and during WPC implementation. Specific universal and variant metrics are required of all WPC pilots and indicated in Attachment MM of the STCs. In addition to these metrics, the evaluation will assess the utility of including additional quantitative metrics using claims and encounter data as applicable for specific target populations. Examples of additional metrics include number of mental health admissions and readmissions, and outpatient service use by subgroups such as the homeless.

Overall Hypothesis and Related Evaluation Questions

The pilots vary in the populations they target and mix of interventions they implemented. In addition, multiple interventions may be implemented simultaneously. For example, a pilot may target jail re-entry and homeless enrollees and design services specifically for these populations with a “package of interventions” that includes infrastructure development, collaboration and information sharing among pilot participants, and care coordination strategies, and other services that are expected to lead to improvements in health outcomes. It is anticipated that the impact of each individual service, or intervention, cannot be observed independently of the other interventions implemented simultaneously. Therefore, the evaluation will 1) assess the impact of the “package of interventions” for each target population within each pilot; and 2) be able to compare the impacts of the various pilots’ interventions for similar target populations.

The evaluation will test the overall hypothesis that the WPC pilot program has achieved the pilot goals in addition to achieving cost savings to the Medi-Cal program. It is hypothesized that WPC will achieve its goals by development of infrastructure to promote integration among pilot entities. Infrastructure will in turn improve collaboration and delivery of high quality care by WPC pilots. These improvements will subsequently lead to better outcomes both in health of the high-risk, high utilizing Medi-Cal beneficiaries and in reducing their health expenditures through reductions in avoidable utilization such as inpatient and emergency department utilization. WPC interventions are sustained when WPC pilots plan to maintain the relationships developed during the program and have embedded care coordination practices in their routine operations.

The specific research questions, as well as data types and sources and the metrics used to address these questions, are displayed in Exhibit 2. The evaluation will assess and report results for all research questions 1) for each pilot and 2) for the entire program.

The evaluation will dedicate the majority of its resources and reporting to answering the research questions that address health outcomes and avoidable utilization reductions of the various pilot packages of interventions for target populations and comparing the outcomes for these packages of interventions. The answers to these questions are of primary importance for determining which interventions were effective and for prioritizing continuation of pilot interventions in the future. As a secondary focus, the evaluation will determine whether challenges in meeting milestones for building pilot infrastructure, enrollment, and service delivery had a detrimental impact on the ability of the pilot interventions to improve health outcome. The evaluation will also determine what other factors promoted or hindered the success of specific strategies in achieving the intended outcomes.

Mid-point and Final Evaluations

The midpoint and final evaluations will report results for the evaluation questions listed in Exhibit 2 to the extent possible with the data available at the points in time when the two reports are completed. The midpoint report, due to CMS on December 30, 2019, or the midpoint of DY 15, will include a more complete assessment of pilot population demographics, pilot intervention descriptions, and progress toward meeting implementation milestones and pilot implementation challenges. The midpoint report will include assessment of care and outcome improvements, though only preliminary pilot outcome data will be available. The final report will provide the complete assessment of pilot care and outcome improvements, including the assessment of the impact of the various packages of interventions for specific target populations. The final report will also include assessment of reductions in avoidable utilization and associated costs, pilot challenges and best practices, and assessments of sustainability.

Analyses Methods

The evaluation will first assess the infrastructure established by WPC pilots including the planning process, improvements in data collection capacity and effort, improvements in data sharing capacity and effort, programmatic changes, and any other successes in integration across pilot participants. Collectively, these efforts are expected to improve the infrastructure needed to coordinate care across diverse health, behavioral health and social service needs of the pilot enrollees. This infrastructure is also essential in ability of the pilots to conduct continuous quality improvement activities, including PDSA cycles to adapt and improve WPC pilot activities.

The evaluation will next assess whether WPC pilots provide “better care” by assessing the planned care coordination activities, availability of care coordination protocols, level of care coordination services delivered, frequency and types of PDSA conducted to improve coordination among pilot participants, and successes and challenges of different pilots’ care coordination strategies. The evaluation will also assess other

indicators of better care as identified in Exhibit 1. These include changes in access to health, mental health, substance use, and social and housing services as well as improved use of follow up outpatient services post-acute and residential service use.

The evaluation will assess whether the infrastructure developed and care coordination strategies implemented by pilots led to better health, measured by improved health status measures as well as reductions in avoidable acute and residential services. The evaluation will use the data available to it to describe any significant external factors that may limit pilot improvements in these areas.

The overall sustainability of the program will be assessed through an examination of the pilots' success in establishing lasting relationships between pilot participants, care coordination process protocols that are embedded in routine practice. The evaluation will also assess the impact of WPC on reduction in Medi-Cal expenditures anticipating that potential cost savings may motivate and promote sustainability in the long term. Assessing the impact of WPC pilots on avoidable utilization, such as inpatient and emergency department utilization, and associated Medi-Cal expenditures, is also important in the decision to scale the program statewide.

The analyses will begin by examining pilot applications and developing a database of program details such as interventions, targeted populations, population selection methods and criteria, universal and variant measures identified in pilot reports, and targets for quantitative universal and variant measures. The evaluation will incorporate new data as they become available, analyze trends in universal and variant metrics, analyze whether pilots met their targets, and compare performance on metrics to targets and national benchmarks as applicable and available. The evaluator will host this information and DHCS will provide the quantitative and the qualitative data needed for the evaluation.

The evaluation team will also develop the questionnaires and key informant interview protocols; pilot test these instruments and protocols with two WPC pilots; and share the instrument with DHCS for feedback. Following pilot tests, the evaluation team will obtain list of key informants; administer the questionnaires online; follow up with key informant interviews; and analyze these data. Simultaneous with other activities and as soon as possible, the evaluation will obtain Medi-Cal data and begin baseline and intervention period analyses.

The quantitative evaluation questions (e.g., outcomes such as hospitalizations and ED visits, mix of mental health and social services, expenditures) will be assessed for the program overall and for specific pilots using a pre-post intervention-control approach to quantitative analyses. The quantitative universal metrics that are available from DHCS Medi-Cal claims and encounter data, such as ED visits and hospitalizations, will be calculated using DHCS claims and encounter data for two baseline years (2015 and 2016 calendar years) to establish an adequate trend in utilization prior to WPC pilot implementation for all pilot enrollees for whom the data is available. This two-year baseline analysis is intended for evaluation of quantitative claims/encounter data.

Thus, for universal and variant metrics that are not available in claims and encounter data, such as metrics that require chart review, the evaluation will rely on self-reported data by each pilot. The evaluation will assess the sample sizes for the variant metrics to determine those most suitable for rigorous impact evaluation and determine alternative methods of assessing these metrics when feasible. For all self-reported data, the baseline year will be 2016. The post implementation trend will be identified for the entire length of the pilot. Please note that the methods listed in this paragraph relate only to the evaluation analysis.(Please note that for calculating metric achievement against pilot goals for incentive payment purposes, DHCS measures PY2 results against baseline data from calendar 2016.)

A control group will also be selected, with consideration of the challenges of this task. This task is challenging because participation in the pilot is not random since pilots frequently target highest risk beneficiaries and those targeted for the intervention have to opt-in and can opt-out at any time. A control group can also be selected from counties not in the pilot, though differences in county delivery systems and population characteristics exist. Therefore, three comparison groups for the evaluation will be considered: 1) beneficiaries selected for participation by the pilot who did not opt-in who have similar risk profile but were unwilling to participate in the program; 2) beneficiaries at the next lower tier of risk within the pilot; and 3) beneficiaries with the same risk profile and similar demographics who reside in non-pilot counties. These comparisons allow an assessment of the program impact that is more independent of potential confounding factors than a simple pre-post evaluation. The evaluation will use the propensity score method to identify the control group from one or more of the groups above when feasible.

The control group will be used to assess the impact of the collective pilot population. A single control group allows for assessment of the overall impact of WPC. It is also more likely to be representative of the entire population targeted by WPC in all the pilot programs than a separate control group for each pilot population. This is particularly because of the potential self-selection bias by specific counties and the lower likelihood of finding counties with similar populations. This strategy would avoid the anticipated difficulty of identifying an adequate number of Medi-Cal beneficiaries in the control group with similar characteristics for each pilot. Because the control group population profile will be designed with the collective pilot population in mind, further assessment is required to determine to what extent the control group can be used as a benchmark to assess the impact of individual pilots and specific target populations within pilots. Also, metric data that is only available by pilot collection and reporting will not be available for the control group. If needed, multiple comparison groups may be included allowing for comparison of the results for each group to gain a better understanding of the WPC impact. DHCS Medi-Cal claims and encounter data will be available for the control group.

If the above strategies in selecting a control group do not lead to selection of a reasonable control group, UCLA will develop a model to predict the counterfactual outcomes of interest (e.g., expenditures) after implementation of the pilots, or as if the

pilots were not implemented. The observed outcomes during WPC will then be compared to the counterfactual predicted outcome during WPC. UCLA will examine all the above methodologies to identify a control group to be used in the analyses of the quantitative data. When quantitative data are not available, for example for social services, UCLA will examine the self-reported data by pilots for baseline and implementation years.

Additional quantitative analyses will be conducted by assessing the degree to which pilots met universal and variant quantitative metrics (such as HEDIS or NQF metrics) and exceeded their own targets and available national benchmarks.

Both descriptive and multivariate regression methods will be used in the quantitative evaluation. The descriptive methods will be used to create a profile of the pilot enrollees overall, and by pilot, in terms of their demographics, health status, WPC pilot service utilization and specific categories of Medi-Cal service utilization. Multivariate methods will be used to assess the overall impact of the WPC demonstration on service use and health outcomes using difference-in-difference (DD) methodology. For example, the DD methodology allows for assessment of the change in number of all-cause ED visits during baseline and pilot implementation periods in both the intervention and control populations. The DD methodology allows for attribution of change to implementation of WPC pilot, if the rate of ED visits declined significantly and at a higher rate among pilot enrollees than the comparison groups. The regression models will control for confounding factors such as demographics, health status and condition severity, length of time enrolled in the pilot, and pilot characteristics when possible. Random effects regression for dichotomous, count, and continuous dependent variables will be constructed, accounting for hierarchical nature of the data and repeated measures from the enrollees.

The descriptive analyses will be reported for WPC overall and for each pilot. The multivariate models will be conducted for the WPC overall.

The qualitative data (e.g., progress reports, questionnaires, and key informant interviews) will be analyzed using a multiple case study design, with counties as the unit of analysis. Case study methods are well suited for studying context-specific processes and will allow for in-depth analyses of individual counties as well as systematic cross-county comparisons. This approach involves three steps: coding, within-case analyses, and between-case analyses. Qualitative data will be analyzed to identify overarching themes (e.g., data and information sharing infrastructure, other collaborative capacity, programmatic changes, barriers to implementation, factors affecting sustainability, promising strategies identified using PDSA cycles) The relative importance of each theme will be examined within and across counties. Sectoral differences will also be assessed. Configurational comparative methods such as qualitative comparative analysis (QCA) will also be applied to the data to identify emerging patterns across counties that result in specified outcomes. A key strength of QCA is that it allows for causal heterogeneity, i.e., more than one way to achieve a specific outcome. Use of this approach will allow a more systematic identification of different combinations of factors

resulting in program failure or success. The qualitative data will also be used to contextualize the quantitative findings.

Evaluation Challenges and Approaches to Address Such Challenges

The WPC pilots evaluation present several challenges:

1) The pilot enrollees have to opt-in and can out-out at will. Some will graduate and others will be newly enrolled. These challenges will be met through employing the DD analyses, incorporating measures of length of enrollment and churn, and analyzing characteristics of those who do not opt-in vs. the eligible population and those who opt-out vs. those who do not.

2) External contextual factors may impact individual pilot results, such as other local or state initiatives that were ongoing or newly embarked on by pilots. These challenges will be met through use of DD analyses and comparing the pilot results with selected comparison groups. In addition, the pilot questionnaires will identify other concurrent or new initiatives that may be complementary or supplemental to WPC strategies.

3) As noted previously, it is anticipated that the impact of each individual service, or intervention, is not likely to be observable independently because the interventions for each pilot's various target populations are provided at the same time as a "package of interventions." Therefore, the evaluation will 1) assess the impact of the "package of interventions" for each target population within each pilot; and 2) compare the impacts of the various pilots' interventions for similar target populations regarding appropriate use of care, reduced inappropriate utilization and improved health outcomes. As part of this comparison, the evaluation will include a description of the package of interventions that each pilot delivered to each target population. Regarding the package of interventions for each pilot target population, the following factors will be described to provide context for the corresponding outcome data analysis:
    a. Eligibility requirements for FFS/PMPM services
    b. Bundled services
    c. Beneficiaries receiving more than one service/intervention
    d. Duration of services
    e. Case manager to beneficiary ratio
    f. Intensity of services: short and intense services vs long and constant
    g. Mechanisms of approach: All-inclusive vs Tiered bundles that lead to "graduation", etc.

4) There are limitations to evaluation's ability to independently assess all the metrics. It is anticipated that universal metrics such as all-cause hospitalizations and emergency department visits can be assessed using Medi-Cal enrollment and claims data. For measures such as jail recidivism or suicide risk assessment, however, only self-reported data by pilots will be available. Similarly, information on use of care coordination policies and procedures or utilization of PDSAs by pilots are limited to data reported by pilots in their annual reports as well as

questionnaire and key-informant data. Therefore, the analyses of such quantitative data will be limited to pre-post analysis and comparison to national benchmarks if such benchmarks are available.

5) Assessing the reductions in avoidable utilization and associated costs due to the pilot is dependent on the availability of expenditure data, particularly for individuals enrolled in Medi-Cal managed care plans, which lack payment information. DHCS will work with the evaluator to assess the feasibility of creating shadow-prices for services delivered to enrolled populations and to calculate the overall expenditures and savings that may be attributed to WPC.

6) The sustainability of WPC strategies in pilots can only be assessed definitively if further assessment of pilot efforts and analyses of metrics were completed at one year or later following conclusion of the pilot. In the absence of such assessment, pilots will be asked to indicate which strategies they plan to continue following WPC conclusion and whether these strategies are embedded within the routine practices of the organization.

Evaluator Selection

The State will contract with an independent entity and ensure that the entity is free of conflict of interest to conduct an evaluation of the WPC Pilots. The State will contract with an entity that does not have a direct relationship to the State of California, Department of Health Care Services (DHCS). The evaluator will not conduct separate evaluations of individual pilots outside of the WPC evaluation contract with DHCS, but the evaluator may evaluate other Medi-Cal 2020 Demonstration Programs. A data use agreement will be included in the contract to allow for the sharing of data with and access to data by the independent entity for purposes of conducing the evaluation. The State sought applications from interested entities that were identified based on prior experience and expertise in analyzing the experience of the population and working with the data that would be analyzed. DHCS scored the proposals and the proposals exceeded the minimum score requirement. The UCLA Center for Health Policy Research was the successful proposer.

Timeline

The proposed timeline for the WPC evaluation is presented below. This timeline identifies the proposed start dates of major evaluation activities. Many of the activities such as analyses of PDSA data, annual reports, and Medi-Cal data will be on-going throughout and to the end of the evaluation. Specific activities such as obtaining IRB approvals are not indicated in the timeline. UCLA will begin the IRB process prior to analyses of claims/encounter data and collection of data from key informants. Obtaining claims and encounter data require an extensive lead-time, particularly due to an anticipated 6 month lag in receipt of claims and encounter data from providers as well as a 3 month lag in adjudicating claims. UCLA will begin negotiations with DHCS to obtain data and anticipates to receive the data within 4-6 months of that request. Pilots submit semi-annual progress reports (including PDSA information), which are due August 31 (mid-year) and April 1 (annual). Quarterly pilot enrollment and WPC service

utilization reports are due 30 days after the end of the quarter. DHCS will provide this information to UCLA when it is received from the pilots.

- July 1, 2017 - Evaluator Selection and Contracting.
- November 1, 2017- Begin analyses of pilot applications and annual reports.
- December 1, 2017- Initiate the process for receipt of Medi-Cal data.
- January 1, 2018- Begin analyses of PDSA data.
- April 1, 2018- Begin first round of questionnaires of WPC pilots and key informant interviews (regarding on multiple domains not systematically addressed in pilot reports).
- May 1, 2018 – Begin analyses of questionnaire and interview data.
- June 1, 2018, Begin analyses of Medi-Cal data.
- December 30, 2019 – Submit Midpoint Evaluation report using all available data, including PDSA and other pilot quarterly and semi-annual reports, questionnaires and interviews, and Medi-Cal data.
- September 1, 2020 – Begin questionnaire of sustainability of pilot strategies.
- November 1, 2020 – Begin analyses of sustainability questionnaire data.
- June 30, 2021 – Submit Final Evaluation report: using all available data, including PDSA and other pilot quarterly and semi-annual reports, questionnaires and interviews, and Medi-Cal data.

Exhibit 2:
Evaluation Questions and Data Sources

Evaluation Question	Data See the DHCS WPC Technical Specifications Manual in the Appendix for more information about Universal and Variant Metrics Specifications and Sources.
Overarching	
1) What are the demographics of pilot enrollees? What services did they receive?	Individual Pilot Mid-Year and Annual Reports: participant information including: 1. Number of beneficiaries participating; active and those that have graduated or transitioned from pilot; 2. Participant characteristics (e.g., demographics, physical and behavioral health diagnoses, baseline rates of ED/IP utilization, housing needs, jail involvement, etc.); and 3. Description of how WPC pilots selected their target population, determined eligibility and if there have been any changes to this group over time.
	Pilot Quarterly Enrollment and WPC Service Reports DHCS Claims and Encounter Data
2) What key factors aided or hindered the success of specific strategies in implementation or in achieving the intended outcomes and what measures are pilots taking to address these barriers?	Key Informant Questionnaires or Interviews with Pilot County Leadership to provide additional context for pilot report and PDSA information.
3) What are the structural differences of the various pilots and	Review of Pilot Applications and Key Informant Questionnaires or Interviews with County Pilot Leadership

how are differential pilot outcomes related to structural differences?	1. Lead and participating entities, their roles and collaboration; 2. Infrastructure, including governance; 3. Overview of the types of care coordination infrastructure pilots have put in place, including navigation infrastructure, coordinated entry, common assessment tools used among participating entities, collection and use of social determinants data, increased access to social services, etc.; 4. Overview of the types of data sharing infrastructure pilots have put in place, including bi-directional data sharing with managed care health plans and participating entities, use of health information exchanges, use of population management systems and predictive modeling, implementation of care and case management software solutions; and use of real time data sharing and notifications to improve health outcomes and coordination of services; 5. Type of services and interventions, including a description of the package of interventions that each pilot delivered to each target population. Regarding the package of interventions for each pilot target population, the following factors will be described to provide context for the corresponding outcome data analysis: a. Eligibility requirements for FFS/PMPM services b. Bundled services c. Beneficiaries receiving more than one service/intervention d. Duration of services e. Case manager to beneficiary ratio f. Intensity of services: short and intense services vs long and constant g. Mechanisms of approach: All-inclusive vs Tiered bundles that lead to “graduation”, etc. 6. Types of incentive payments, Pay for Reporting and Pay for Outcomes, including to downstream providers; 7. Housing pool information, if applicable; and 8. Other local related efforts that may interact with and/or support WPC (i.e., health homes, DMC waiver).

Infrastructure	
4) To what extent did the pilot: A) develop collaborative leadership, infrastructure, and systematic coordination among public and private WPC Pilot entities, including county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries; and B) achieve the approved application deliverables relating to collaboration, infrastructure and coordination?	Individual Pilot Mid-Year and Annual Report information: 1. Data and other documentation demonstrating progress toward WPC Pilot goals in relation to the infrastructure and other coordination and collaboration strategies. 2. A narrative describing the activities and interventions the WPC Pilot performed as described in the application including barriers, challenges, and successes. .
	Key informant Questionnaires or Interviews with County Pilot Leadership and other Pilot Entities to provide further context to the report information described above.
5) To what extent did the pilot: A) improve data collection and information sharing amongst local entities to support identification of target populations, ongoing case management, monitoring, and strategic program improvements in a sustainable fashion; and B) achieve the approved application deliverables relating to data collection and information sharing?	Individual Pilot Mid-Year and Annual Report: 1. Data and other documentation as described in the WPC Pilot application demonstrating progress toward WPC Pilot data collection and information sharing goals, infrastructure, and strategies, such as bidirectional data sharing with Medi-Cal Managed Care Plans, Health Information Exchange, Real-time data sharing between pilot entities 2. A narrative describing the data collection and information sharing activities and interventions, including barriers, challenges, and successes.
	Universal Metric Data and Information Sharing Policy and Procedure Deliverable: Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and all participating entities that provide for streamlined beneficiary care coordination, case management, monitoring, and· strategic improvements, to

	the extent permitted by applicable state and federal law. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval. These shall include processes to monitor, compile and assess monitoring information, and update policies as needed in accordance with a PDSA process. (See Attachment MM for additional information.)
	Key Informant Questionnaires or Interviews with County Pilot Leadership or other Pilot Entities to provide additional context for the information noted above.
Better care	
6) To what extent did the pilot: A) improve comprehensive care coordination, including in-real-time coordination, across participating entities; and B) achieve the approved application deliverables relating to care coordination?	Individual Pilot Mid-Year and Annual Report information: 1. Data and other documentation as described in the WPC Pilot application demonstrating progress toward WPC Pilot goals in relation to the infrastructure, services, and other strategies for care coordination, including standardized care plans and "in real time" coordination. 2. A narrative describing the care coordination activities and interventions, including barriers, challenges, and successes.
	Universal Metric: Proportion of participating beneficiaries with a comprehensive care plan accessible by the entire care team within 30 days of: 1. Enrollment into the WPC Pilot. 2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually).
	Universal Metric Care Coordination Policy and Procedure Deliverable: Submission of documentation demonstrating the establishment of care coordination, case management, and referral policies and procedures across the WPC Pilot leads and all participating entities, which provide for streamlined beneficiary case management. Upon completion, and within a timeline approved

	by the State, the policies and procedures will be submitted to the State for review and approval. These shall include processes to monitor, compile and assess monitoring information, and update policies as needed in accordance with a PDSA process. (See Attachment MM for more information.)
	Key Informant Questionnaires or Interviews with Pilot County Leadership and Other Pilot Entities to Provide Additional Context for the Data Noted Above. DHCS Claims and Encounter Data
7) To what extent did the pilot: A) increase appropriate access to care and social services; and B) achieve approved application deliverables relating to WPC service delivery?	Individual Pilot Mid-Year and Annual Report information: 1. Data and other documentation demonstrating progress toward WPC Pilot goals in relation to the infrastructure, medical and social services, and other strategies. 2. A narrative describing the activities and interventions for each component as described in the application including barriers, challenges, and successes.
	Key Informant Questionnaires or Interviews with Pilot County Leadership and Other Pilot Entities.
	DHCS Claims and Encounter Data: This data source will be used to gather DHCS-provided universal and variant metric data as well as any of other utilization data that the evaluation determines to be useful to measure increases in appropriate access to care such as preventive outpatient services.
	Pilot Quarterly Enrollment and WPC Service Reports.
8) To what extent did the pilot increase access to housing and supportive services and improve housing stability, if applicable?	Variant Metric: Percent of Homeless Permanently Housed for Greater Than Six Months.
	Variant Metric: Percent of Homeless Receiving Housing Services in the Pilot Year That Were Referred for Housing Services.

	Variant Metric: Percent of Homeless Referred from Supportive Housing Who Received Supportive Housing.
Better Health	
9) To what extent did the pilot (and individual target population packages of services): A) improve beneficiary care and health outcomes, including reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient); and B) improve outcomes such as controlled blood pressure and HbA1c?	Individual Pilot Mid-Year and Annual Reports. Pilot Quarterly Enrollment and WPC Service Reports DHCS Claims and Encounter Data
	Universal Metric: Ambulatory Care – Emergency Department Visits (modified from HEDIS).
	Universal Metric: Inpatient Utilization – General Hospital/Acute Care (IPU) (modified from HEDIS).
	Universal Metric: Follow-up After Hospitalization for Mental Illness (FUH) (modified from HEDIS).
	Universal Metric: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (modified from HEDIS).
	Variant Metric: 30 Day All Cause Readmissions (modified from HEDIS).
	Variant Metric: Decrease Jail Recidivism.
	Variant Metric: Overall Beneficiary Health (derived from CAHPS).
	Variant Metric: Controlling High Blood Pressure (modified from HEDIS).
	Variant Metric: Comprehensive Diabetes Care – HbA1c Control (modified from HEDIS).
	Variant Metric: Depression Remission at 12 months (PHQ-9).
	Variant Metric: Suicide Risk Assessment Completion.
	Other Optional Pilot-developed Metrics.
	Other DHCS Medi-Cal Claims and Encounter Data as Needed.
Lower costs and sustainability	
10) To what extent did WPC pilots reduce costs of care for enrolled	DHCS Claims and Encounter Data: These data will be used to assess the impact of the pilot on the costs incurred by beneficiaries compared to those

beneficiaries compared to the control group and were total Medi-Cal expenditures reduced during the pilot?	incurred by the comparison group(s) before and after the intervention. The impact of the WPC on Medi-Cal expenditures before and after the pilot implementation will also be assessed.
11) What lasting collaboration between pilot participants and care coordination protocols will continue after the pilot? In addition, how will counties ensure that improvements achieved by the pilots are sustained after pilot funding is exhausted?	Key Informant Questionnaires or Interviews with County Pilot Leadership.