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

Los Angeles County
Annual Narrative Report, Program Year 4
April 16, 2020

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	☐ 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.

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.

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

WPC-LA continues to build and leverage its relationships with county agency partners, community stakeholders, health plans, providers and others to enhance integration of service delivery models and evaluate and build capacity of service providers. With the vision and framework set forth in California's Advancing and Innovating Medi-Cal (CalAIM) Initiative, close collaboration with these stakeholders is required in order to ensure sustainability of WPC-LA programs post 2020.

In PY4, we continued to refine our existing partnerships and developed new ones to enhance outreach and engagement activities for WPC-LA. We forged a new partnership with the Children's Health Outreach Initiatives (CHOI) to provide community-based outreach and engagement activities for adults to access WPC-LA programs. We also implemented a new outreach and engagement program targeting chronically homeless individuals, utilizing multi-disciplinary street outreach teams with the Department of Health's Housing for Health (HFH) Division and through their partnership with the Los Angeles Homeless Services Authority's (LAHSA's) street outreach teams.

Through our partnership with the Department of Public Health, WPC-LA established 10 school wellness centers focused on providing trauma informed care to at-risk youth, launched a program to develop capacity in the community for doulas to serve mothers with high infant mortality risk and implemented a hospital based violence intervention training program in geographic regions with high rates of violence and trauma.

We evaluated our Transitions of Care (TOC) program and explored opportunities to expand our program to other L.A. County hospitals. By way of approval from DHCS, we expanded our TOC hospital criteria to include high volume Medi- cal hospitals in L.A. County. In PY4 we built relationships and referral pathways with 3 identified hospitals (based on the revised hospital criteria), resulting in the expansion of the TOC program.

As we plan for WPC-LA programs to be transitioned to managed care plans at the conclusion of the existing waiver, we are working closely with managed care plans and our Health Agency partners to evaluate existing program models and determine a roadmap for transition and sustainability under the Medi-cal managed care infrastructure. This work has resulted in ongoing, continuous collaboration with county agency partners, Medi-cal managed care plans, trade association and other stakeholders. This work will continue into PY 5, thereby continuing to increase WPC-LA's integration with L.A County's broader health care and social service ecosystem.

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

WPC-LA continues to work to increase linkage to housing through our housing-related programs. Although L.A. County is experiencing challenges with available housing stock, WPC-LA surpassed PY4 targets to develop interim and permanent supportive housing beds. We continue to work with the Department of Mental Health and the Office of Diversion and Reentry to support access to housing and supportive services for specialized populations.

Due to the shortage of housing stock in L.A. County, WPC-LA continues to navigate challenges in facilitating expedient access to housing through L.A. County's Coordinated Entry System operated by the LAHSA. In response, WPC-LA continues to train and educate program social workers and Community Health Workers (CHW's) on how to connect clients to the Coordinated Entry System and the best approach for maintaining that connection until a housing match is made.

WPC-LA remains committed to enhancing the capacity of current community-based stabilization housing providers. Through approved WPC rollover funds from PY3-PY4, we have been able to provide additional support to stabilization housing operators through "downstream provider" payments. This additional support increases the capacity of stabilization housing operators to care for WPC-LA participants with complex health, mental health, social and/or behavioral issues that do not qualify for skilled nursing facilities, but need enhanced care and supervision with ADLs by increasing staffing and services. WPC-LA surpassed its PY4 stabilization housing targets by adding 101 Community Placement Program beds and remains committed to supporting stabilization housing providers in PY5. We are currently working to increase our Medi-cal match rate for individuals matched to a stabilization housing provider that is supported by WPC-LA funds.

In addition to supporting stabilization housing providers in L.A. County, WPC-LA continues to work on developing interim housing bed capacity. In PY4, we greatly surpassed both targets for interim and recuperative care respectively by adding 482 interim housing and 520 recuperative care beds to these housing stocks and will continue to grow these beds in PY5.

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

WPC-LA continued to improve and enhance care coordination processes in PY4 in order to reduce inappropriate health care utilization and improve health outcomes for the WPC population.

As WPC-LA prepares for the transition of programs post 2020, we continue to focus and hone processes and protocols related to PCP assignment, scheduling PCP appointments and transition/handoff to primary care. This will support our care teams (social works and community health workers) in ensuring WPC-LA participants have a longitudinal care management provider when exiting their WPC-LA program. WPC-LA provided multiple trainings for Community Health Workers on the standardized protocols. We continue to monitor primary care linkage outcomes and identify opportunities for standardized work and process improvement related to these activities.

In addition to standardizing care coordination protocols, we have also explored new programs and models that enhance our ability to provide more effective care coordination to WPC-LA enrollees. In PY4 we planned for implementation of our TOC Enroller program. TOC enrollers are responsible for all pre-enrollment activities, including referral receipt and triage; participant visit preparation; participant outreach, engagement, and enrollment; initiation of certain participant linkages; and all outreach and enrollment related documentation. They then hand off the participant to another CHW who cares for them post-enrollment as they transition from the hospital back to their homes and communities. This allows our CHWs to spend more time on direct care coordination activities with enrollees, rather than having to split time between outreach and engagement as well.

During PY4, we implemented a WPC Pharmacy program focused primarily on serving our Transitions of Care clients with the primary outcomes of reducing medication-related complications and medication-related readmissions. In PY4, we had 8 advanced practice clinical pharmacists in place. They are fully integrated with our WPC teams and can receive referrals from CHWs and CHAMP. The goal is to refer all TOC clients for high-risk medication consult. The clinical pharmacists provide post-discharge care coordination support, medication reconciliation, medication education, health education, coaching and more. Thus far, we have many success stories for these TOC clients, and we are excited to have these pharmacists integrated into our WPC teams.

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

In PY4, WPC-LA continued its work on facilitating greater care coordination activities for WPC-LA enrollees by leveraging data and information sharing mechanisms and partnering with L.A. County's Health Information Exchange (HIE). By establishing a data sharing relationship with L.A. County's HIE, LANES, WPC-LA can share Personally Identifiable Information (PII) on WPC participants which is then matched to HL7 Admit

Discharge Transfer like data. This allows WPC-LA care teams to better understand and respond to the acute needs of their clients. This also provides the opportunity for WPC-LA care teams to have access to Continuity of Care Documents (CCD) tied to patient encounters and a complete medical history for a patient as it exists in LANES.

For other stakeholders that have also partnered with LANES, such as Federally Qualified Health Clinics (FQHCS), WPC- LA is working on establishing a mechanism for those medical providers to know what CBO their patient may be working with if they are enrolled in WPC-LA. This will provide more opportunities to coordinate care for high risk patients across acute and ambulatory care settings.

In the early part of PY4, WPC-LA also established a bidirectional data sharing exchange with our partner health plans to share WPC enrollee information with their respective managed care organization and receive important health and utilization data in return on those enrollees. This has opened a broad array of opportunities to collaborate further with health plans now that we can share data on specific enrollees. Examples of areas of focus for data exchange with the health plans include reports on:

1) Overlap between WPC enrollees also on Health Homes TEL
2) Pharmacy data (e.g. drug interactions, polypharmacy)
3) Hotspotting
4) Gaps in care

WPC-LA is currently working to develop targeted interventions based on report findings.

III. 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	**3,201**	**1,492**	**1,540**	**1,683**	**1,776**	**1,836**	**11,528**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	2,155	1.547	1,549	1,559	1,296	1,233	20,867

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*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
Service 1	**$279,245.27**	**$252,972.42**	**$347,607.81**	**$167,931.27**	**$239,459.59**	**$321,879.20**	**$1,609,095.50**
Utilization 1	**709**	**670**	**804**	**832**	**825**	**909**	**4,749**
Service 2	$196,650.00	$185,850.00	$201,600.00	$233,325.00	$238,050.00	$288,900.00	$1,344,375.00
Utilization 2	874	826	896	1,037	1,058	1,284	5,975
Service 3	$1,414,353.02	$1,393,445.14	$1,426,101.50	$1,468,502.73	$1,548,932.21	$2,155,860.74	$9,407,195.35
Utilization 3	1,417	1,299	1,282	1,349	1,722	1,562	8,631

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	$254,191.77	$346,362.98	$242,946.27	$251,020.60	$243,126.79	$248,988.79	$3,195,732.71
Utilization 1	899	874	899	783	799	673	9,666
Service 2	$352,575.00	$387,900.00	$351,000.00	$425,025.00	$315,000.00	$313,425.00	$3,489,300.00
Utilization 2	1,567	1,724	1,560	1,889	1,400	1,393	15,508
Service 3	$1,586,702.09	$1,567,220.82	$1,475,871.99	$1,570,769.01	$1,519,027.06	$1,591,597.30	$18,718,383.62
Utilization 3	1,535	1,554	1,456	1,784	1,641	1,323	17,924

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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*

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
PMPM 1 (BA)	$810.54	**$791,091.43**	**$413,377.70**	**$478,221.26**	**$470,926.35**	**$549,549.17**	**$453,094.38**	**$3,156,260.28**
MM Counts 1		**976**	**510**	**590**	**581**	**678**	**559**	**3,894**
PMPM 2 (HCSS)	$406.64	**$3,758,555.07**	**$3,828,903.44**	**$3,900,471.73**	**$3,969,600.19**	**$4,088,338.49**	**$4,259,533.09**	**$23,805,402.02**
MM Counts 2		**9,243**	**9,416**	**9,592**	**9,762**	**10,054**	**10,475**	**58,542**
PMPM 3 (TSS)	$132.00	**$1,220,074.48**	**$1,242,910.45**	**$1,266,142.42**	**$1,288,582.39**	**$1,327,126.34**	**$1,382,698.27**	**$7,727,534.36**
MM Counts 3		**9,243**	**9,416**	**9,592**	**9,762**	**10,054**	**10,475**	**58,542**
PMPM 4 (Med RC)	$6061.88	**$1,345,738.10**	**$1,260,871.73**	**$1,272,995.50**	**$1,291,181.15**	**$1,563,965.90**	**$1,721,574.87**	**$8,456,327.25**
MM Counts 4		**222**	**208**	**210**	**213**	**258**	**284**	**1,395**
PMPM 5 (Psych RC)	$9639.89	**$2,294,293.26**	**$2,516,010.68**	**$2,853,406.75**	**$3,065,484.27**	**$2,776,287.64**	**$2,631,689.33**	**$16,137,171.93**
MM Counts 5		**238**	**261**	**296**	**318**	**288**	**273**	**1,674**
PMPM 6 (Post-jail)	$398.46	**$211,184.44**	**$233,498.26**	**$243,061.33**	**$241,865.95**	**$215,169.05**	**$277,329.00**	**$1,422,108.02**

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
MM Counts 6		**530**	**586**	**610**	**607**	**540**	**696**	**3,569**
PMPM 7 (Post-comm)	$789.65	**$296,908.40**	**$297,698.05**	**$316,649.65**	**$324,546.15**	**$356,921.80**	**$437,466.10**	**$2,030,190.15**
MM Counts 7		**376**	**377**	**401**	**411**	**452**	**554**	**2,571**
PMPM 8 (Post-extend)	$398.46	**$181,697.76**	**$200,026.92**	**$207,199.20**	**$226,723.74**	**$241,865.22**	**$251,826.72**	**$1,309,339.56**
MM Counts 8		**456**	**502**	**520**	**569**	**607**	**632**	**3,286**
PMPM 9 (Juvenile)	$779.65	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
MM Counts 9		**0**	**0**	**0**	**0**	**0**	**0**	**0**
PMPM 10 (Pre-release)	$1585.28	**$608,747.31**	**$661,061.53**	**$699,108.24**	**$697,522.96**	**$529,483.33**	**$813,248.36**	**$4,009,171.72**
MM Counts 10		**384**	**417**	**441**	**440**	**334**	**513**	**2,529**
PMPM 11 (ISR)	$1074.60	**$424,468.95**	**$410,499.09**	**$391,156.20**	**$414,797.51**	**$423,394.35**	**$396,529.23**	**$2,460,845.33**
MM Counts 11		**395**	**382**	**364**	**386**	**394**	**369**	**2,290**
PMPM 12 (RBC)	$2134.43	**$1,336,150.40**	**$1,391,645.46**	**$1,528,248.70**	**$1,530,383.12**	**$1,767,304.36**	**$1,878,294.49**	**$9,432,026.53**

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
MM Counts 12		**626**	**652**	**716**	**717**	**828**	**880**	**4,419**
PMPM 13 (RBCECC)	$3206.31	**$115,427.00**	**$57,713.50**	**$60,919.81**	**$92,982.86**	**$92,982.86**	**$67,332.42**	**$487,358.44**
MM Counts 13		**36**	**18**	**19**	**29**	**29**	**21**	**152**
PMPM 14 (SUD)	$562.69	**$48,391.29**	**$51,204.74**	**$69,210.80**	**$75,963.07**	**$86,654.17**	**$102,972.17**	**$434,396.24**
MM Counts 14		**86**	**91**	**123**	**135**	**154**	**183**	**772**
PMPM 15 (TOC)	$440.82	**$41,437.03**	**$44,963.58**	**$52,457.51**	**$71,412.75**	**$75,380.13**	**$67,004.56**	**$352,655.56**
MM Counts 15		**94**	**102**	**119**	**162**	**171**	**152**	**800**
PMPM 16 (KTP)	$1242.32	**$494,443.36**	**$506,866.56**	**$527,986.00**	**$531,712.96**	**$539,166.88**	**$542,893.84**	**$3,143,069.60**
MM Counts 16		**398**	**408**	**425**	**428**	**434**	**437**	**2,530**
PMPM 17 (MAMA)	$748.19	**$389,059.51**	**$421,979.93**	**$426,469.07**	**$468,367.79**	**$478,094.28**	**$487,072.57**	**$2,671,043.15**
MM Counts 17		**520**	**564**	**570**	**626**	**639**	**651**	**3,570**

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
PMPM 1 (BA)	$810.54	$564,949.52	$391,492.99	$525,232.84	$452,283.83	$377,713.74	$387,440.27	$5,855,373.47

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
MM Counts 1		697	483	648	558	466	478	7,224
PMPM 2 (HCSS)	$406.64	$4,457,972.44	$4,463,665.37	$4,526,694.26	$4,274,172.06	$4,372,985.09	$4,441,300.28	$50,342,191.52
MM Counts 2		10,963	10,977	11,132	10,511	10,754	10,922	123,801
PMPM 3 (TSS)	$132.00	$1,447,114.19	$1,448,962.19	$1,469,422.17	$1,387,450.27	$1,419,526.23	$1,441,702.20	$16,341,711.61
MM Counts 3		10,963	10,977	11,132	10,511	10,754	10,922	123,801
PMPM 4 (Med RC)	$6061.88	$1,836,750.65	$1,860,998.18	$1,970,112.08	$1,776,131.82	$1,497,285.18	$1,424,542.58	$18,822,147.75
MM Counts 4		303	307	325	293	247	235	3,105
PMPM 5 (Psych RC)	$9639.89	$2,612,409.55	$2,448,531.46	$2,149,694.95	$1,985,816.86	$1,706,260.11	$1,590,581.46	$28,630,466.33
MM Counts 5		271	254	223	206	177	165	2,970
PMPM 6 (Post-jail)	$398.46	$284,102.84	$292,470.52	$275,336.69	$306,416.66	$294,462.83	$317,175.12	$3,192,072.67
MM Counts 6		713	734	691	769	739	796	8,011
PMPM 7 (Post-comm)	$789.65	$507,744.95	$461,945.25	$468,262.45	$448,521.20	$459,576.30	$436,676.45	$4,812,916.75
MM Counts 7		643	585	593	568	582	553	6,095

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
PMPM 8 (Post-extend)	$398.46	$281,711.22	$286,492.74	$308,408.04	$370,169.34	$395,670.78	$438,306.00	$3,390,097.68
MM Counts 8		707	719	774	929	993	1,100	8,508
PMPM 9 (Juvenile)	$779.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MM Counts 9		0	0	0	0	0	0	0
PMPM 10 (Pre-release)	$1585.28	$776,786.93	$759,348.85	$705,449.35	$779,957.49	$667,402.65	$700,693.51	$8,398,810.50
MM Counts 10		490	479	445	492	421	442	5,298
PMPM 11 (ISR)	$1074.60	$391,156.20	$397,603.83	$222,443.22	$287,994.13	$326,679.90	$376,111.73	$4,462,834.35
MM Counts 11		364	370	207	268	304	350	4,153
PMPM 12 (RBC)	$2134.43	$2,036,241.98	$2,100,274.75	$2,277,432.07	$2,416,169.73	$2,443,917.26	$2,610,402.45	$23,316,464.77
MM Counts 12		954	984	1,067	1,132	1,145	1,223	10,924
PMPM 13 (RBCECC)	$3206.31	$51,300.89	$89,776.56	$44,888.28	$83,363.94	$44,888.28	$38,475.67	$840,052.06
MM Counts 13		16	28	14	26	14	12	262
PMPM 14 (SUD)	$562.69	$118,164.78	$130,543.95	$112,537.89	$95,657.20	$75,963.07	$70,898.87	$1,038,162.00

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
MM Counts 14		210	232	200	170	135	126	1,845
PMPM 15 (TOC)	$440.82	$69,208.65	$78,906.68	$80,229.14	$82,874.06	$66,122.92	$61,273.90	$791,270.90
MM Counts 15		157	179	182	188	150	139	1,795
PMPM 16 (KTP)	$1242.32	$557,801.68	$532,955.28	$705,637.76	$649,733.36	$532,955.28	$441,023.60	$6,563,176.56
MM Counts 16		449	429	568	523	429	355	5,283
PMPM 17 (MAMA)	$748.19	$508,021.93	$534,956.82	$567,129.05	$561,891.71	$546,927.88	$543,186.93	$5,933,157.47
MM Counts 17		679	715	758	751	731	726	7,930

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 into WPC each month, except for January which indicates how many clients were enrolled (new and continuing) in the first month of 2019.

The costs under the FFS table reflect our actual incurred costs and/or estimated cost depending on the program.

All numbers have changed since the mid-year report, indicated by **bold** font.

IV. 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.

WPC-LA continues to hire staff to support the core and essential operations of the WPC team. However, given the expiration WPC-LA at the end of 2020, hiring permanent positions is challenging. We are looking at strategies to fill staffing needs such as utilizing existing staff or contractors.

We are nearly at full staffing levels for some of our teams. Full staff will include 11 positions for program governance, 16 positions for IT infrastructure, and 110 positions for carrying out program work and service delivery.

We currently have a total of 76 positions filled with a majority staff dedicated to program development, support and evaluation (52 positions). As we continue to upgrade functionality to our care management platform (CHAMP), we hired 4 staffing resources dedicated to the CHAMP training team.

Over PY 4, we hired 32 contractors through our temporary personnel services agreement to fulfill key needs in building WPC infrastructure and services. The following positions were hired in 2019 to facilitate strategic goals in CHAMP training and workflow documentation; Benefits Advocacy program administration; and clinical pharmacy med reconciliation and stabilization during high-risk transitions for WPC clients:

- 1 Admin Assistant II - HFH CHAMP Staffing
- 1 Staff Analyst - HFH CHAMP Staffing
- 3 Admin Asst I - HFH CHAMP Staffing
- 1 Asst Staff Analyst - HFH CHAMP Staffing
- 1 Senior Staff Analyst - CHAMP Management/ IT
- 1 Information System Analyst - CHAMP System Architecture
- 4 Admin Asst I - Benefits Advocacy
- 2 Asst Staff Analyst - Benefits Advocacy
- 11 CHW - Benefits Advocacy
- 1 Staff Analyst - Benefits Advocacy
- 6 Clinical Pharmacists

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.

We have continued to invest in the development of CHAMP, the web-based care coordination platform we utilize for delivering WPC services. For this reporting period, we focused on system enhancements that would further operationalize the data sharing framework outlined in the Universal Consent, streamline service delivery, and improve data collection. We added new functionality to enable the use of the single Universal Consent form across multiple integrated programs and improve consent management as part of the privacy and security upgrade. In parallel, we added functionality to streamline service delivery and data collection specific to our jail reentry programs, and to improve tracking of outreach and engagement efforts across WPC programs. In total, we released five significant CHAMP system enhancements in these focus areas. To support user adoption of the new features, our CHAMP Training Team created training materials including reference guides, job aids, and interactive videos and conducted 38 in-person trainings and webinars to reach approximately 3,603 CHAMP users.

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.

Please refer to the invoice for a detailed accounting of each WPC-LA incentive payment we are claiming for the annual report and dollar amounts.

WPC-LA is claiming payment for 36 milestone incentives and one downstream incentive totaling $102,705,851.60 for the PY4 annual report. Payments to WPC-LA is for work done to achieve the incentives.

Highlights of our achievements for PY4 include:

1) Increasing bed capacity for recuperative care, interim and community placement program.
2) Open 10 wellness centers at schools, with a focus on trauma-informed care
3) Launch a program to build capacity in the community for doulas for mothers in populations with high infant mortality
4) CHAMP trainings for new and existing WPC staff, includes trainings on new functionality added to CHAMP within the program year
5) Develop curriculum and train 20 providers in Naloxone use
6) Hire 8 new pharmacists to provide MAT in the community
7) Partner with 3 high-volume Medi-cal hospitals to improve access to WPC and other County services for their Medi-Cal populations
8) Develop post-acute placement pathway delineating procedures for coordinating placement for hospitalized patients who are hard-to-place due to homelessness or behavioral issues

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.

Pay-for-reporting
WPC-LA is reporting on all three universal and variant metrics required at 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 PY4.

WPC-LA is claiming payment for 36 pay-for-outcome metrics totaling $49,825,000.00 for the annual report. Payments to WPC-LA is for work done to achieve the outcome.

Some highlights of our achievements this year include:

1) A 5% reduction in hospitalization rate per 1,000 Medi-Cal Member Months 6 months after enrollment compared to 6 months before to WPC-LA program
2) 2% reduction per year from baseline in 30-day all cause readmission rate for medically high-risk individuals
3) Serve at least 300 clients through WPC-LA Medical Legal Partnership program
4) Provide at least 75% of adult justice-involved individuals with a 30-day supply of chronic medications
5) House at least 75% of WPC-LA clients who are permanently housed for at least 6 months

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:
"WPC-LA_PY4AnnualReport_StakeholderEngagement_Final_20200416" for a complete list of our stakeholder engagement activities.

VIII. PROGRAM ACTIVITIES

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

In PY 4, WPC-LA continued to standardize and enhance care coordination procedures. In addition to our continuous performance improvement work driven by our PI team, social workers and CHWs, WPC-LA identified innovative opportunities to increase outreach and engagement and enhance care coordination services:

1. During PY4, we developed a revised approach to outreach and engagement of TOC participants that adds an additional staff role – a CHW Dedicated Enroller. This approach is currently implemented at 2 of 4 TOC hospitals, with planning and design taking place during most of PY4. CHW Enrollers are responsible for all pre-enrollment activities: referral receipt and triage; participant visit preparation, participant outreach, engagement, and enrollment; initiation of certain participant linkages; and all outreach and enrollment related documentation. They then hand off the participant to another CHW who cares for them post-enrollment as they transition from the hospital back to their homes and communities. So far, we have seen success from separating the outreach and engagement function out from care management – namely, an increase in enrollment volumes at some sites. We are excited to continue to monitor this approach as our new Enrollers become more seasoned in their roles.
2. During PY4, we implemented a WPC Pharmacy program focused primarily upon serving our Transitions of Care clients with the primary outcomes of trying to reduce medication-related complications and medication-related readmissions. In PY4, we had 8 advanced practice clinical pharmacists in place. They are fully integrated with our WPC teams and can receive referrals from the CHWs and CHAMP. The goal is to refer all TOC clients for high-risk medication consult. The clinical pharmacists provide post-discharge care coordination support, medication reconciliation, medication education, health education and coaching and more. Thus far, we have many success stories for these TOC clients, and we are excited to have these pharmacists integrated into our WPC teams.

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

1. As WPC-LA focuses on ensuring participants are handed off to a longitudinal care management provider, we struggle with developing a standardized protocol across our programs to identify the best type of provider for participants and how to conduct a handoff. For some participants, a primary care provider may be most appropriate to provide longer term case management services. However, for other participants that may have more social service focused needs, a PCP may not be the best fit. We've also come across scenarios where

participants do not want to be supported by their PCP yet finding other types of long-term support in the community remains difficult. Depending on who the most appropriate provider is, how the participant is transitioned varies as well. This has presented challenges when trying to develop a standardized training and protocol for our CHWs. We currently have developed various approaches to this work depending on the program, region and participant's choice.

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

1. Our main success with data and information sharing involves the work we have recently undertaken to share Personally Identifiable Information (PII) with the LANES Health Information Exchange (HIE). This effort to facilitate greater care coordination for our WPC participants leverages programmatic access to our CHAMP database to support the creation of an active roster of WPC participants that are matched to data in LANES. This creates a WPC cohort within the HIE that we can monitor. The benefit here is that WPC team members will be able to access a dashboard that contains Health Level 7 (HL7) Admit Transfer Discharge (ADT) like data on WPC participants. For the clinical teams this helps them better understand the care their patients are accessing in the community. Additionally, social work team leads will be able to use this data to help their staff better understand the needs of their clients. For Federally Qualified Health Clinics (FQHCs) and other medical staff using the LANES portal, it will soon help them know which Community Based Organizations (CBOs) are working with a patient and how they might be able to reach out to those care team members to better coordinate discharge. The LANES data will also allow WPC analysts and clinical team members the ability to pull in HL7 Continuity of Care Document (CCD) data. This will allow for as much of a complete medical history for a patient as exists within the HIE. An added bonus is that this data will also flow into the DHS Electronic Health Record (EHR) platform via a "community health record" button that clinicians will have access to. This will help us overcome an obstacle that has been challenging since the start of our WPC program. Similar approaches may be available with other LANES-connected EHRs countywide.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1. Since our WPC Care Management Platform, CHAMP, is still not integrated with EMRs across the county, it can be difficult to share information with our hospital and clinic partners, particularly as this pertains to Health Homes overlap. We have many manual workarounds in place to circumvent information siloes. We also continue to consider broad data sharing needs across our platforms and systems for CalAIM.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. In connection to data collection, our main victory has been in the creation of many useful database views within our Azure replication of the production CHAMP SQL Server database. The views we are creating and documenting dramatically reduce the time analysts and program staff spend in getting to the data they care about. In efforts to improve program documents, we are filling in the gaps by adding robust data dictionaries on the DHS IT SharePoint site that contains many useful tables for the main database views that matter most to both WPC operations and clinical teams as well as potential analytics and evaluation use cases. Furthermore, we are creating our own Entity Relationship Diagrams (ERDs) so in a future state we have reliable, clear, and careful documentation of our participant data. Without this documentation and the ERDs it is difficult to facilitate data sharing with other systems; therefore, we view this work as setting ourselves up for success as WPC transitions to CalAIM. Moreover, the benefit of this work is that the data can also be accessed programmatically, which opens new opportunities vis-a-vis tooling that was previously not possible. One example of this is that we can now build dashboards that will update at the point of access, which means less redundant work for analysts, more real-time data for operations and clinical teams, and more time for leadership and analysts to begin deeper analytics and evaluation work that can help improve program delivery and planning for the entire WPC population.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. Due to limitations with our IT Change Management process, the Comprehensive Needs Survey that we enhanced and modified through significant performance improvement efforts in PY3 and PY4 is still currently being administered on paper. The CHWs upload the scanned PDF into the client's record and can continue to access that information for individual care coordination purposes. However, it is currently not possible to access aggregated data from these surveys for evaluation and risk stratification purposes.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
The biggest barrier to success for WPC is COVID 19. Given the limitations in community and hospital-based work during the pandemic response, we anticipate enrollment numbers significantly dropping in the upcoming 3-6 months. The unknown nature of the pandemic - when it will be resolved, if there will be a resurgence of the virus, etc. - makes it difficult for us to plan for the remainder of the program year. This coupled with WPC-LA being in the final program year results in a great potential for WPC-LA to not use all allocated funds in the PY5 budget. However we do remain committed to serving this population and are exploring opportunities for the WPC-LA program to support emergency response efforts to COVID 19 along with continuing to provide care coordination support to participants telephonically.

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.

Please refer to the attached PDSA Summary Report and individual PDSAs for more detail. A list of PDSAs completed in PY4 are below:

1. SASH Line Referrals*
2. CHAMP Training Videos*
3. SUD PowerInsight Report*
4. Scheduling and Access Challenges & Barriers*
5. Comprehensive Needs Survey*
6. Community Health Worker Time Management Study*
7. Primary Care Provider Accompaniment Phase 2: Protocol Development and Training*
8. CHW Follow Up: Reducing Wait Times*
9. Improving Medi-Cal activation rates for the Re-Entry program
10. Referral Conversion Rates
11. Release Desk Pass Through
12. Release Desk Standardization
13. Substance Use Disorder (SUD) PowerInsight Report: Harbor-UCLA
14. Community Health Worker Time Management Study
15. Transitions of Care Dedicated Enroller Pilot
16. WPC Universal Consent

*Reported at mid-year report period