# Whole Person Care – Los Angeles

Lead Entity:

Los Angeles County Department of Health Services

Revised May 18, 2017

## 1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.B.I)

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| Organization Name | Los Angeles County Department of Health Services |
| Type of Entity (from lead entity description above) | County |
| Contact Person | Mark Ghaly, MD, MPH |
| Contact Person Title | Deputy Director, Community Health & Integrated Programs |
| Telephone | (213) 240-8107 |
| Email Address | mghaly@dhs.lacounty.gov |
| Mailing Address | 313 N. Figueroa Street, Room 904B<br>Los Angeles, CA 90012 |

## 1.2 Participating Entities

| Required Organizations | Organization Name | Contact Name and Title | Entity Description and Role in WPC (Please also See Section 2.2) |
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| 1. Health Services Agency/ Department | Los Angeles County Department of Health Services | Mark Ghaly, MD, MPH Deputy Director, Community Health & Integrated Programs | Public hospital system. Will serve as the WPC lead entity. |
| 2. Medi-Cal managed care health plan | L.A. Care Health Plan | John Baackes, Chief Executive Officer | The nation's largest publicly operated health plan. As a lead health plan, will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; develop data sharing methodology for population health management and reporting; and identify, refer, and coordinate services for WPC patients. |
| 3. Specialty Mental Health Agency/ Department | Los Angeles County Department of Mental Health | Robin Kay, PhD, Acting Director of Mental Health | Public mental health care services provider. Will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; develop data sharing methodology for population health management and reporting; support administration of WPC mental health high-risk programs. |

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| 4. Public Agency/ Department | Housing Authority of the County of Los Angeles | Sean Rogan, Executive Director | Administers the Section 8 housing choice voucher and public housing programs for LAC residents. Will participate as an affiliate entity; support WPC Homeless High-Risk Programs through matching of federal rental subsidies. |
| 5. Community Partner 1 | Los Angeles Regional Re-entry Partnership | Troy Vaughn, LARRP Chair; President and CEO of Christ-Centered Ministries | Network of public, community- and faith-based agencies and advocates working to support the development and implementation of Los Angeles' re-entry system. Will participate in planning WPC programs and decision-making as a principal entity participating in monthly leadership meetings; support development and implementation of WPC justice-involved programs. |
| 6. Community Partner 2 | Skid Row Housing Trust | Mike Alvidrez, CEO | Supportive housing developer, operator and service provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| Additional Organizations (Optional) | Organization Name | Contact Name and Title | Entity Description and Role in WPC |
| 7. Medi-Cal managed care health plan | Anthem Blue Cross | Les Ybarra, Executive Director | Medi-Cal delegated health plan provider. Will participate and give input through LA Care Health Plan and participate in biannual health plan meetings as an affiliate entity; participate in development of data sharing methodology for population health management and reporting as necessary; identify, engage, refer, and coordinate services for WPC clients. |
| 8. Medi-Cal managed care health plan | Care1st Health Plan | Martha Tasinga, MD, MBA, Medical Director | Medi-Cal delegated health plan provider. Will participate and give input through LA Care Health Plan and participate in biannual health plan meetings as an affiliate entity; participate in development of data sharing methodology for population health management and reporting as necessary; identify, engage, refer, and coordinate services for WPC clients. |

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| 9. Medi-Cal managed care health plan | Kaiser Permanente | Gwendolyn Leake-Issacs, Managing Director Medi-Cal State Programs | Medi-Cal delegated health plan provider. Will participate and give input through LA Care Health Plan and participate in biannual health plan meetings as an affiliate entity; participate in development of data sharing methodology for population health management and reporting as necessary; identify, engage, refer, and coordinate services for WPC clients. |
| 10. Medi-Cal managed care health plan | Health Net | Patricia Clarey, Chief State Health Programs and Regulations Relations Officer | As a lead Health Plan, will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; develop data sharing methodology for population health management and reporting; and identify, refer, and coordinate services for WPC clients. |
| 11. Medi-Cal managed care health plan | Molina Healthcare (subcontract of Health Net) | Milaine Issac, Associate VP, Market Leader | Medi-Cal delegated health plan provider. Will participate and give input through Health Net and participate in biannual health plan meetings as an affiliate entity; participate in development of data sharing methodology for population health management and reporting as necessary; identify, engage, refer, and coordinate services for WPC clients. |
| 12. Public Agency/ Department | Los Angeles County Sheriff's Department | Sheriff Jim McDonnell, County Sheriff | Law enforcement agency serving the County of Los Angeles. Will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; develop data sharing methodology for population health management and reporting; and identify, refer, and coordinate services for WPC clients; support WPC jail re-entry programs through expansion of re-entry service linkages. |
| 13. Public Agency/ Department | Housing Authority of the City of Los Angeles | Carlos Van Natter, Director of Section 8 | Public housing authority providing the largest supply of quality affordable housing to residents of the City of Los Angeles. Will participate as an affiliate entity; support WPC Homeless High-Risk Programs through matching of federal rental subsidies. |

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| 14. Public Agency/ Department | Los Angeles County Department of Probation | Richard Giron, Senior Probation Director | County agency that provides services for adults and juveniles placed on probation within Los Angeles County. Will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; develop data sharing methodology for population health management and reporting; and identify, refer, and coordinate services for WPC clients; |
| 15. Public Agency/ Department | Los Angeles County Department of Public Health | Jeffrey Gunzenhauser, MD, MPH, Interim Health Officer | County public health agency that provides public health services related to environmental health, communicable disease control, substance abuse prevention and control, and emergency preparedness to residents of Los Angeles County. Will participate in planning WPC programs and decision-making as a principal entity participating in monthly leadership meetings; facilitate community partnerships. |
| 16. Public Agency/ Department | Substance Abuse Prevention and Control, Department of Public Health (joint letter with LAC DPH) | Wayne K. Sugita, Interim Executive Director | County public agency that provides substance abuse prevention educational services and treatment for individuals with Substance Use Disorders (SUDs) in LAC. Will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; support development and implementation of WPC SUD high-risk programs. |
| 17. Public University/ Academic Medical Center | University of California Los Angeles Health | Santiago Munoz, Chief Strategy Officer | Public university, academic medical center and regional health provider. Will participate in planning WPC programs and decision-making as a principal entity, participating in monthly leadership meetings; contribute to the development of WPC recuperative care and sobering center facilities. |
| 18. Community Partner | Alliance for Housing and Healing | Terry Goddard II, Executive Director | Non-profit housing agency. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 19. Community Partner | Downtown Women's Center | Anne Miskey, CEO | Los Angeles homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider; will provide homeless services tailored to women |

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| 20. Community Partner | GettLove | Keegan Hornbeck, MSW, Program Director | Los Angeles homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 21. Community Partner | Homeless Health Care Los Angeles | Mark Casanova, Executive Director | Los Angeles homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 22. Community Partner | LifeSTEPS | Craig Gillett, JD, MFT, President | Life skills training and education provider for homeless and vulnerable Los Angeles residents. Will participate as an affiliate entity; will be a WPC HCSS provider. |
| 23. Community Partner | Mental Health America | David Pilon, Ph.D., President and CEO | Integrated mental health and homeless services provider in Long Beach and Antelope Valley. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 24. Community Partner | Ocean Park Community Center | John Maceri, Executive Director | West L.A. homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 25. Community Partner | Pacific Clinics | Sue Shearer, Senior Vice President | Non-profit mental health and homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 26. Community Partner | SSG/Hopics | Veronica Lewis, MPA, Division Director | Skid Row region homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 27. Community Partner | St. Joseph Center | Va Lecia Adams Kellum, Executive Director | Venice, Santa Monica, Mar Vista homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 28. Community Partner | Step Up on Second | Tod Lipka, CEO | Housing and vocational services agency in West LA. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 29. Community Partner | Volunteers of America - Greater Los Angeles | Shanita Seamans, Program Manager | Homeless service provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |
| 30. Community Partner | Watts Labor Community Action Committee | Timothy Watkins, CEO and President | Homeless services provider. Will participate as an affiliate entity; will be a WPC Homeless Care Support Services (HCSS) provider. |

## 1.3 Letters of Participation and Support

Letters of participation were received from the Participating Entities listed in Section 1.2. and from the following additional organizations listed below and available by calling Mark Ghaly, MD, MPH (213) 240-8107, for copies of letters.

| Letters of Support | |
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| Organization Name | Contact Name and Title |
| 1. All-Inclusive Community Health Center | Marine Dzhgalyan, CEO |
| 2. Alma Family Services | Jean G. Champommier, Ph.D., President/CEO |
| 3. AltaMed Health Services | Cástulo de la Rocha, J.D., President/CEO |
| 4. Antelope Valley Community Clinic | James A. Cook, CEO |
| 5. Antelope Valley Partners for Health | Michelle Kiefer, MBA, Executive Director |
| 6. Antelope Valley Transit Authority | Len Engel |
| 7. Bartz-Altadonna Community Health Center | Emma Gutierrez, CEO |
| 8. Black Community Health Task Force | Ernie Smith, Ph.D. |
| 9. California Black Women's Health Project | Sonya Young Aadam, CEO |
| 10. California Department of Corrections and Rehabilitation | Diana L. Toche, D.D.S., Undersecretary of Health Care Services |
| 11. California Long-Term Care Education Center | Corinne Eldridge, Executive Director |
| 12. City of Palmdale | James Purtee, City Manager |
| 13. Community Health Councils | Veronica Flores, M.A., CEO |
| 14. Community Partners in Care | Loretta Jones, M.A., Founder/CEO |
| 15. Comprehensive Community Health Centers | David Lontok, Executive Vice President |
| 16. Conrad N. Hilton Foundation | Bill Pitkin, Director, Domestic Programs |
| 17. Corporation for Supportive Housing | Beth Stokes, Managing Director |
| 18. Each One-Teach One Alliance for Academic Achievement and Success | Dr. Chris L. Hickey, Sr., Executive Director |
| 19. Glendale Healthier Community Coalition | Edna Karinski, Chair |
| 20. Great Beginnings for Black Babies, Inc. | Rae Jones, MBA, Executive Director |
| 21. Health Care LA | Iris Weil, Executive Director |
| 22. Health Consortium of Greater San Gabriel Valley | Ernest P. Espinoza, Co-Chair |
| 23. Healthy African American Families II | Loretta Jones, M.A. Th.D., Founder/CEO |
| 24. Hope of the Valley Rescue Mission | Ken Craft, President/CEO |

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| 25. L.A. Care Family Resource Center | Margaret Coins, Administrator |
| 26. Los Angeles County Board of Supervisors | Hilda L. Solis, Chair, Supervisor, First District |
| 27. Los Angeles County Chief Executive Office | Sachi A. Hamai, CEO |
| 28. Los Angeles County Chief Executive Office-Homeless Initiative | Phil Ansell, Director, Homeless Initiative |
| 29 Los Angeles Homeless Services Authority | Peter Lynn, Executive Director |
| 30. Los Angeles Mission | Herbert L. Smith, President/CEO |
| 31. Mission City Community Network, Inc. | Nik Gupta, President/CEO |
| 32. Northeast Valley Health Corporation | Kimberly Wyard, CEO |
| 33. Our Place Housing Solutions | Chrissy Padilla Birkey, MUA, Executive Director |
| 34. Partners in Care Foundation | W. June Simmons, President/CEO |
| 35. Preparation & Awareness for Community Resiliency in Emergencies & Disasters | Alicia Hamilton, President |
| 36. Safety Net Connect, Inc. | Keith Matsutsuyu, CEO |
| 37. Samuel Dixon Family Health Center, Inc. | Philip Solomon, MPA, CEO |
| 38. San Fernando Community Health Center | Audrey L. Simons, MSHA, CEO |
| 39. Service Employee International Union (SEIU) Local 2015 | Laphonza Butler, Provisional President |
| 40. SEIU Local 721 | Bob Schoonover, President |
| 41. South LA Health Project | Heidi Kent, MPH RD, Executive Director |
| 42. Southside Coalition of Community Health Centers | Nina L. Vaccaro, MPH, Executive Director |
| 43. SPIRITT Family Services | Elvia Torres, Executive Director |
| 44. The Wellness Center | Rosa Soto, Executive Director |
| 45. Tarzana Treatment Centers | Albert M. Senella, President/CEO |
| 46. The Revelation Network | Alicia Hamilton, CEO |
| 47. To Help Everyone (THE) Health and Wellness Centers | Clifford Shiepe, President/CEO |
| 48. University Muslim Medical Association (UMMA) Community Clinic | Miriam Y. Vega, MD, CEO |
| 49. UniHealth Foundation | Mary Odell, President |
| 50. Venice Family Clinic | Elizabeth Benson Forer, MSW/MPH, CEO and Executive Director |
| 51. Worker Education & Resource Center, Inc. | Diane Factor, Director |

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| 52. University of California, Los Angeles Clinical and Translational Science Institute (CTSI) | Steven Dubinett, Associate Vice Chancellor for Research - David Geffen School of Medicine at UCLA and Director, Clinical and Translational Science Institute |

## 2.1 Geographic Area, Community and Target Population Needs

### Background and Context

Whole Person Care Los Angeles (WPC-LA) will operate in Los Angeles County (LAC), the largest county in California, spanning over 4,000 square miles and home to 10 million people. LAC is one of the most ethnically and racially diverse areas in the nation with residents coming from 140 countries and speaking 200 languages. LAC has both rural and urban regions (88 cities), including some of the most densely populated areas in the country. To facilitate system planning and community-based programming, LAC is divided into eight County Service Planning Areas (SPAs), geographic designations around which county health services are organized (see map).

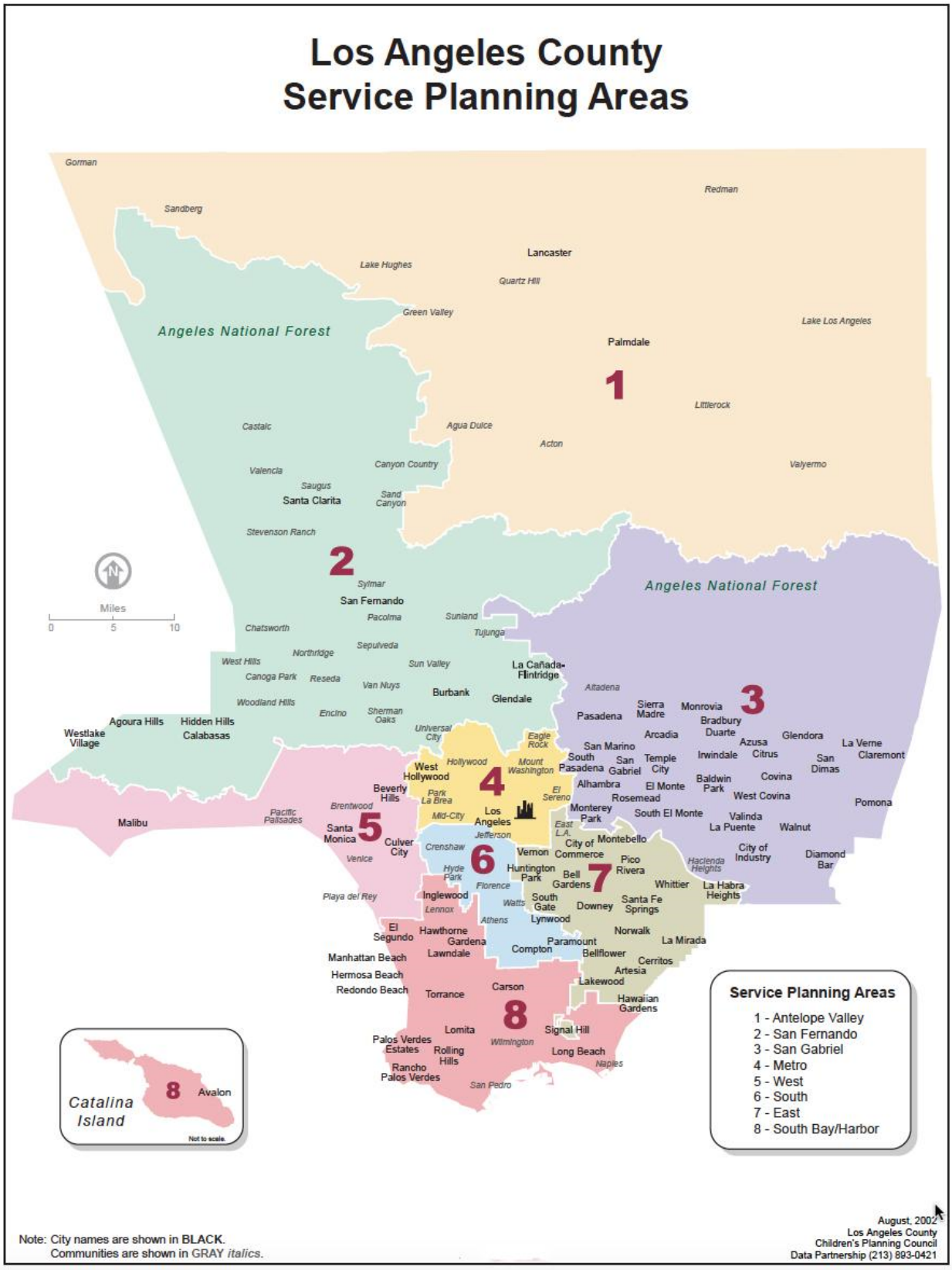
While LAC is known across the nation for pockets of wealth, the share of LAC residents living below the federal poverty level is higher than the state average (17.1% in LAC vs. 15.3% statewide in 2008-2012)[1]. Among the large Medi-Cal population, a sick, vulnerable subgroup account for a disproportionate share of the total health-related expenditures. In the face of poverty, these individuals grapple with multiple medical and psychiatric comorbidities, poor access to resources and information, lack of hope and self-efficacy, low health literacy, poor social/community support, and residence in unsafe and chaotic environments. These biological, psychosocial, and environmental issues make individuals particularly vulnerable to gaps in the health delivery system, putting them at risk for adverse complications of chronic conditions, frequent and avoidable acute care utilization, homelessness, incarceration, and premature death. While these beneficiaries often receive services from different parts of Los Angeles' extended health delivery system, including physical health, behavioral health, and social service providers, these entities frequently work in silos, and thus expose those they serve to both duplicated effort and gaps in care, at great cost to local, state, and federal governments.

### Participating entities and countywide collaboration

As the lead entity, the LAC Department of Health Services (DHS) worked with a coalition of health and social service delivery entities across the county to develop the vision and structure of WPC-LA. We drew input from numerous entities, including health plans (e.g., L.A. Care, Health Net and their delegated plans), community-based providers (e.g., Partners in Care, multiple homeless service providers), and community-based and non-profit organizations (e.g., Los Angeles Regional Re-entry Partnership, SEIU). Many sent representatives to more than 50 WPC-LA work group meetings over two months on the design of the WPC pilot, including target population selection and interventions, data and metric development, and implementation plan and budget. WPC-LA builds upon years of work planned and implemented throughout LAC.

1 US Census Bureau data; downloaded from calbudgetcenter.org

Los Angeles County Service Planning Areas (SPA) Map



## General description of Whole Person Care – Los Angeles

The vision of WPC-LA is to ensure that the most vulnerable Medi-Cal beneficiaries have the resources and support they need to thrive. The pilot will bring together health and social service delivery entities across the county to build a more client- and community-centered system of care and develop the foundational infrastructure necessary to deliver seamless, coordinated services to Medi-Cal populations across the county. We will create and apply a WPC "Toolkit" across a wide range of target populations in LAC, delivering services they need, when and where they need them, with the ultimate goal of reducing reliance on public institutions and programs, reducing avoidable acute care utilization, and improving the health and well-being of target populations that are often overlooked and underserved.

WPC-LA will target the needs of six high-need Medi-Cal populations: 1) individuals experiencing homelessness, 2) justice system involved individuals, and individuals who are high-utilizers of acute care services due to 3) serious mental illness (SMI), 4) substance use disorder (SUD), 5) complex medical issues, and 6) high-risk pregnant women. A brief summary of each target population follows.

(1) Homeless High-risk: According to a January 2016 homeless count, 46,874 people are homeless in LAC.[2] These individuals lack basic necessities (e.g., food, shelter) that are foundational to health. When sick, they are less able to prioritize health issues and often present late in the course of illness, resulting in frequent emergency department and/or psychiatric emergency service visits or inpatient hospital stays. Lack of access to affordable interim and permanent supportive housing results in these individuals subsequently returning to streets and shelters, perpetuating a cycle that ultimately leads to poor health outcomes, high medical expenditures, and premature death.

(2) Re-entry: Despite numerous health issues and challenges when returning to the community post-incarceration, justice system involved individuals receive little re-entry planning and are released without linkages to necessary services or community-based providers. Upon re-entry, they face numerous challenges, including homelessness, unemployment, reintegrating with their families and re-enrolling in benefits, all while dealing with their acute and chronic medical issues. These competing priorities, poor knowledge of the healthcare system, and poor access to care lead to care and service delays, reliance on costly emergency care, and ultimately poor health outcomes.

(3) Mental Health High-risk and (4) Substance Use Disorder (SUD) High-risk: Individuals with high-utilization driven by behavioral health issues are often poorly engaged with the physical and behavioral health delivery systems and are not well served by existing care coordination models. As a result, many are undertreated for their mental illness as well as for co-existing medical conditions. SUD, either alone or when co-occurring with SMI or complex medical conditions, further hinders one's ability to navigate the health delivery system and attain the resources needed to improve health. Both individuals with SMI and those with SUD often suffer from exposure to cumulative trauma and toxic stress that can be a major driver of frequent avoidable interactions with the health delivery system.

(5) Medically complex: Medical high-utilizers have multiple, often poorly-controlled chronic conditions and co-occurring behavioral health issues. Even when engaged with primary care, teams primarily deliver clinic-based, visit-focused care with little infrastructure to address social determinants of health and are often insufficiently resourced to engage these individuals in a way that successfully meets their needs. Community-based care coordinators are usually not integrated into primary care teams, and

2 2016 Homeless Count Results, Los Angeles Homeless Services Authority.

primary care-based care coordinators - when they exist - are often overwhelmed by the needs of these individuals. In this context, the mix of chronic medical conditions, often exacerbated by mental illness, SUD and social vulnerability, lead to frequent avoidable emergency department visits, hospitalizations, poor health outcomes, and premature death.

(6) Perinatal High-Risk: Strong Start, a federally funded project that DHS received as a grantee, finished its three-year intervention (2014-2016) to improve healthy birth outcomes. MAMA's Neighborhood started as local Strong Start activities within LAC DHS hospitals to provide high-risk pregnant women with comprehensive prenatal services through care coordination to treat the unmet physical, social, and behavioral needs of clients. From treating the highest risk patients of MAMA's Neighborhood, the highly prevalent reports of resource instability (housing, food, income); alcohol, tobacco, and drug use; and physical and emotional trauma are common risk factors among those at risk during times surrounding childbirth.

WPC-LA has designed one or more programs to address the challenges facing each of these target populations, as summarized in the table below. These ten programs will put together a novel set of interventions that will address some of the most pressing challenges facing the health and social services safety net.

Table 2.1: Summary of WPC-LA Programs

| Target Population | Program |
|---|---|
| Homeless High-Risk | Homeless Care Support Services |
| | Benefits Advocacy |
| | Recuperative Care |
| | Psychiatric Recuperative Care |
| | Sobering Center |
| | Tenancy Support Services |
| Justice-involved High-Risk | Community Re-entry:<br>• Adult Jail<br>• Adult Community Referral<br>• Adult Extended Care<br>• Juvenile Aftercare |
| | Enhanced Care Coordination Re-entry |
| Mental Health High-Risk | Intensive Service Recipient |
| | Residential and Bridging Care |
| | Kin to peer |
| Substance Use Disorder (SUD) High-Risk | SUD - Engagement, Navigation and Support |
| Medically Complex | Medically Complex Transitions of Care |
| Perinatal High-Risk | MAMA's Neighborhood |

## Whole Person Care Toolkit

LAC will work with our participating entities to build a WPC-LA Toolkit that each program will use to help build a seamless, integrated health delivery system for each of the target populations. The 13 tools that comprise the WPC Toolkit are described below:

1. Care support and coordination: A core element of all WPC-LA programs is the use of care management strategies that bridge care and services delivered in disparate locations by disparate personnel in order to build a coordinated and comprehensive plan for each patient.
2. Mobile Health Care Support Teams: We will deploy mobile, multidisciplinary health care support services teams to address the complex care needs of WPC-LA clients through care planning, navigation to services, and care coordination.
3. Connection to clinical services: We will arrange referrals and connections to core clinical services already reimbursable through Medi-Cal.
4. Direct provision of non-Medi-Cal-reimbursable clinical and support services: We will deliver clinical or care support services that are not Medi-Cal reimbursable solely due to the setting in which they are delivered.
5. Physical infrastructure: We will add key physical infrastructure elements (e.g., recuperative care, sobering centers) that will enable us to provide more comprehensive services to WPC clients across LAC. Please note that funds from WPC-LA will NOT be used for expansion of the portion of the County's housing pool that provides rental subsidies.
6. Training and performance improvement: We will build a new collaborative Training Institute for the County. Working with key training partners across the county (e.g., SEIU, Worker Education Resource Center, and the California Long Term Care Education Center), the Training Institute will train WPC-LA health and social service delivery staff to improve care for our highest risk clients, with a particular focus on the training and integration of community health workers (CHWs), and countywide training for both WPC-LA teams and other providers on important, cross-cutting content, including motivational interviewing, harm-reduction, recovery and trauma-informed care principles. We will also build a performance improvement infrastructure to support WPC-LA program leaders and delivery teams in use of data-driven, continuous quality improvement approaches (e.g. Plan Do Study Acts or "PDSAs") to ensure that we maximize the reliability and value of each WPC-LA intervention.
7. Use of new workforce members: WPC-LA will develop a "novel" workforce strategy in which we will employ workforce members that are not typically involved in care of the target population. In particular, CHWs, including those with life experiences shared by the target population, will be integral members of our care management teams across WPC-LA pilot programs, creating numerous opportunities for low-income LAC residents to do meaningful work by more effectively engaging WPC clients and providing them with tailored health care support services.
8. Outreach and engagement: We will employ mobile, community-based engagement approaches out of our Regional Coordinating Centers.
9. Housing and placement support services: We will provide move-in assistance, tenancy support, and help manage landlord interactions. We will link enrollees to interim and permanent supportive housing and to rental subsidies via federal rental subsidies and the non-WPC funded housing pool.
10. Enabling services: We will support benefits establishment and provide enhanced care support supplements as needed.

11. Care management platform (CMP): We will build a tool that supports WPC-LA care management teams and allows the interdisciplinary care plan to be visible across providers in real-time.
12. Other information technology (IT) solutions: Beyond the CMP, other IT solutions will enable countywide care coordination and navigation; these include:
    a. Community resource platform – a searchable, continuously updated, web-based platform that connects LAC residents to community resources and enables referral tracking.
    b. Client Track – a housing IT platform that enables management of client intake and triage, as well as continuous tracking of clients and housing units.
13. Countywide data integration: We will bring together critical information through a data integration approach and apply advanced analytics to identify high-risk individuals in multiple settings (e.g., emergency departments, hospitals, institutes of mental disease and jails).

We will implement and use these tools across the WPC-LA programs to build the foundation for ongoing, countywide collaboration, and work towards sustainable improvements in health for our sickest, most vulnerable county residents.

Community Partner Engagement

Meaningful engagement of community partners will be critical to the success of the WPC-LA pilot. Community partners will deliver critical services, including behavioral health treatment, housing support and intensive case management services. They will engage a broad group of community stakeholders within their own networks, and build coalitions to drive community planning and development. This will help us better understand community needs and gaps in our delivery infrastructure, and enable us to work together to address them and the needs of WPC-LA patients.

The Department of Public Health Area Health Officers have led extensive community engagement efforts, including quarterly community networking events that draw 50-70 individuals within each SPA. These events are opportunities to develop and strengthen relationships. During these networking events, stakeholder subgroups hold smaller workgroup meetings to address community needs, including issues that are directly relevant to WPC (e.g. housing, incarceration). This infrastructure will be the foundation for WPC-LA community engagement efforts. We will engage interested community stakeholders at quarterly networking meetings in each SPA and organize monthly (and eventually, quarterly) WPC-LA Community Team meetings. WPC community liaisons will work under area health officers to build coalitions with community members and community partners in all 8 SPAs. Armed with systems-level data, and through the use of case-based discussions (confidentiality protected), these workgroups will collaboratively problem-solve around the specific needs of WPC-LA clients, work together to expand services and funding in their regions, support resource and knowledge sharing, and ensure bi-directional communication of information between WPC-LA core entities and community-based partners. WPC-LA will work with our area health offices and through Community Team meetings to support community capacitation efforts across the county.

## Sustainability

Over the course of the WPC-LA pilot, DHS will work with the government and non-government partners to ensure that the application and implementation of the WPC toolkit is sustained. The WPC pilot provides an opportunity to build critical and lasting infrastructure (e.g., physical and IT infrastructure) and bring the different parts of our health delivery system together. We anticipate that the relationships formed through WPC-LA will drive health system transformation for years to come. Additionally, WPC provides an opportunity to implement innovative programs, and then be able to study

and improve them over the course of the five-year pilot. We anticipate that in this time period, we will be able to improve the efficiency of programs and demonstrate their value to others. We believe a path to fiscal sustainability is ultimately to invite investment in the WPC infrastructure from other entities across our delivery system. To that end, we hope to take successful programs and infrastructure, demonstrate their value, and develop them as high-value, evidence-based "products" that health plans and providers can purchase to improve care for their patients. Similarly, a shared resource like the Training Institute could invite investment or be self-sustaining through contracted delivery of services.

LAC's implementation of the health homes opportunity through the Affordable Care Act, anticipated in 2018, will provide an ongoing and sustainable opportunity to invest in health care support services initially provided through WPC-LA. As health homes are implemented in LAC, we will assess the impact on WPC-LA program components and vice-versa. In doing so, we will work closely with our health plan partners to ensure that the health homes build upon the foundation created by WPC-LA. Finally, we will produce an annual sustainability reports to support ongoing efforts to ensure sustainability of programs after the pilot period. Through these opportunities, we expect many of the approaches and services developed within WPC-LA to be maintained beyond the conclusion of the WPC Pilot.

## 2.2 Communication Plan

DHS, as the lead entity, will operationalize WPC-LA through creation of a central WPC-LA 'Hub', an administrative and clinical leadership team that will oversee and coordinate WPC-LA operations (e.g., IT, contracting), communications (internal and external), programs, and stakeholder engagement. As a core duty, the WPC-LA Hub will create a shared, multi-stakeholder governance structure, described below, that is able to achieve collaboration across all participating entities and ensure that investments in infrastructure and services are coordinated and aligned with WPC goals. The Hub will embrace a transparent and open approach to communication and partner engagement throughout the post-application submission and pilot periods. The main point of contact to support and coordinate with all participating entities is Mark Ghaly, MD, MPH, Deputy Director, LAC DHS.

The governance structure is comprised of four groups: Principal, Affiliate, Foundation, and Evaluation. These are each described briefly below.

Principal: Principal entities will jointly make all major programmatic and funding decisions. They will be engaged during regular monthly (and eventually, quarterly) leadership meetings where Hub leadership will share program updates, review progress on metrics and PDSA activities, problem solve challenges, and consider any changes in program direction or resource allocation that are necessary to optimize pilot outcomes. They will work to achieve consensus in all decisions. Where there is dissent, issues will be decided by simple majority vote. In addition to leadership meetings, DHS, via the Hub, will convene four quarterly WPC subcommittees: finance, service delivery, data and evaluation, and community engagement. These focused subcommittees will oversee these key aspects of WPC-LA operation and ensure multi-stakeholder engagement.

- Principal entities include: LAC DHS, Department of Mental Health (DMH), Department of Public Health/Substance Abuse Prevention and Control (DPH SAPC), Sheriff's Department (LASD), Probation Department, L.A. Care Health Plan, Health Net Health Plan, LA County and LA City Housing Authorities, LA Regional Reentry Partnership and University of California, Los Angeles (UCLA).

Affiliate: Affiliate entities will be involved in governance and decisions about specific aspects of the WPC Pilot in which they are involved. We will keep open communication channels with Affiliate entities, share progress updates, and invite continuous feedback from this group including periodic update webinars. Importantly, this group will include all delegated health plans and community partners. We will hold separate biannual meetings with all delegated health plan partners to discuss WPC progress and invite their input. This will ensure their active participation and input into the pilot, encourage ongoing referrals, and ensure that WPC-LA complements and fully leverages existing health plan programs for WPC-LA clients. We will also use these meetings to discuss the impending Health Homes program and ensure that the two initiatives align and build on one another.

- Affiliate entities include: L.A. Care and Health Net delegated health plans, California Department of Corrections and Rehabilitation, Exodus Recovery Inc., AltaMed, Community Clinics Association of Los Angeles County, HealthCare LA Independent Practice Association, Worker Education and Resource Center (WERC), ARC, LANES, Safety Net Connect (SNC), DHS Housing for Health's contracted Homeless Care Support Service Providers, and other community partners.

Foundation: Foundation partners will raise awareness for the pilot and support dissemination of lessons learned.

- Foundation entities include: Hilton Foundation, The California Endowment, UniHealth Foundation, and others.

Evaluation: Evaluation partners will help develop risk stratification approaches and bring methodological expertise and support to pilot dissemination, implementation, and improvement activities. They will also help disseminate the work of the pilot through formal publications and presentations.

- Evaluation entities include: UCLA Clinical and Translational Science Institute (CTSI), USC-GEHR Center for Implementation Science, RAND Corporation.

Through our WPC-LA community engagement strategy (see Section 2.1 - community engagement), we will engage a broad set of community stakeholders within each SPA, extending beyond participating entities. Building off of the existing, well-attended community engagement meetings led by the LYZTAC DPH Area Health Officers, WPC-LA will engage communities on a monthly (and eventually, quarterly) basis at the local and regional level to build upon local assets, build coalitions, and engage in collaborative community planning to improve care for vulnerable county residents. We will also encourage community partners to provide ongoing feedback on WPC-LA activities and services through a "suggestions box" on the public WPC-LA website.

A summary of anticipated regular meetings is provided below.

Table 2.2: Schedule of Anticipated Regular Meetings

| Group Meeting | Yearly Schedule | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Principal Entities | X | X | X | X | X | X | X | X | X | X | X | X |
| Affiliate Entities | X | | | | | | X | | | | | |
| RCC Leadership | X | X | X | X | X | X | X | X | X | X | X | X |
| WPC-LA Subcommittees | X | | | X | | | X | | | X | | |
| Community Health Team | X | X | X | X | X | X | X | X | X | X | X | X |

Integration across partners: We will work closely with all partners to promote integration and minimize silos. By creating formal opportunities for discussion and feedback through regular meetings and the WPC-LA website, and open informal communication pathways, we will ensure that points of duplication and fragmentation are brought to the attention of leadership and addressed in a proactive and timely way. We will achieve client-level care integration through the implementation of the WPC Care Management Platform (CMP), which will be available for use by all service providers. Through the platform all providers, with appropriate permissions, will be able to see and update care plans, care management notes, and contact information for all care managers, primary care providers and core providers involved in the client's care. This custom-built tool will be shared across providers of different disciplines serving the same client.

To support regional ownership of each program and to facilitate the local deployment of WPC-LA programs in order to meet the unique needs and circumstances of each region, we will establish eight

SPA-based Regional Coordinating Centers (RCCs) that will serve as the regional operations center for each County-wide program, and as the "home base" for each site-based project in a specific SPA. This regional approach is built upon existing infrastructure LAC DPH has in place with their Area Health Officer (AHO) offices, a structure that has strong ties with the surrounding communities within each SPA. The alignment in both vision and mission between WPC-LA and the AHOs is strong, a fact that will help to make use of this existing structure an effective means through which to base communication strategies. RCC leadership will meet monthly with WPC-LA leaders to identify needs, problem solve, and ensure consistent delivery of the planned intervention across the pilot through continuous process improvement activities.

Beneficiary Communication: We will raise awareness for WPC-LA services among Medi-Cal beneficiaries through community-based outreach and marketing, working through our community partners, community forums, and WPC-LA CHWs, who will be hired from the same communities as our WPC-LA clients, to raise awareness for WPC-LA services. We will also work with our Health Plan, provider, and community partners to disseminate posters, flyers, and other advertising materials about WPC-LA services. We will also create a public-facing WPC-LA Website that will a) communicate to external partners and public on WPC-LA programs, b) host a client portal and information center with links to client resources through the community resource platform, and c) share a data dashboard that tracks participation in WPC-LA programming countywide. These tactics will allow for increased uptake of WPC-LA services among Medi-Cal beneficiaries and maintain open communication pathways with the LAC community.

Enrolled clients will receive written information about WPC-LA services when enrolled in the pilot, will be offered a written copy of their goals and service plan each time it is updated, and will be provided with information on how to contact their primary case manager or CHW, health plan, and primary medical and/or behavioral health providers.

## 2.3 Target Population

LAC has selected six five target populations to serve through WPC-LA programs – persons experiencing homelessness, persons with justice system involvement, persons experiencing serious mental illness (SMI), those with substance use disorders (SUDs) medically complex individuals, and high-risk pregnant mothers. These target populations have significant overlap and where they do not overlap, they still have similar features in terms of relative difficulty engaging into programs and their common struggle to manage an array of debilitating social inequities. For this reason, WPC-LA has adopted a "no wrong door" approach where enrollees will be linked via program staff and the CMP to the WPC-LA services they need. WPC-LA is prepared to engage and enroll patients from these target populations through many different doors, including hospitals and emergency departments, primary care clinics, mental health and SUD providers, correctional facilities, locked and unlocked community care settings, housing providers, and other community organizations.

Below are detailed descriptions of each target population, a summary of estimates of total enrollees and enrollee member months for each population (Table 2.3a), and a summary of program eligibility, duration of services, and description of how we will avoid duplication (Table 2.3b).

Table 2.3a: Summary of number of enrollees by Target Population

| | Deliverables | | Annual Caseload Type | PY2 | PY 3 | PY 4 | PY 5 | Estimated Total * |
|---|---|---|---|---|---|---|---|---|
| Homeless | Homeless Care Support Services | | Enrollees | 4,900 | 7,300 | 9,700 | 10,000 | 31,900 |
| | | | Member Months | 52,200 | 74,400 | 103,200 | 119,700 | 349,500 |
| | Benefits Advocacy | | Enrollments | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| | Recuperative Care | | Enrollees | 1,080 | 1,512 | 1,512 | 1,512 | 5,616 |
| | | | Member Months | 2,700 | 3,780 | 3,780 | 3,780 | 14,040 |
| | Psychiatric Recuperative Care | | Enrollees | 45 | 315 | 540 | 720 | 1,620 |
| | | | Member Months | 135 | 945 | 1,620 | 2,160 | 4,860 |
| | Sobering Center | | Encounters | 23,269 | 32,850 | 32,850 | 32,850 | 121,819 |
| | Tenancy Support Services | | Enrollees | 4,900 | 7,300 | 9,700 | 10,000 | 31,900 |
| | | | Member Months | 52,200 | 74,400 | 103,200 | 119,700 | 349,500 |
| Justice | Community Re-entry | Adult Jail Referral | Enrollees | 12,000 | 15,000 | 15,000 | 15,000 | 57,000 |
| | | | Member Months | 32,250 | 45,000 | 45,000 | 45,000 | 167,250 |
| | | Adult Community Referral | Enrollees | 1,200 | 2,400 | 2,400 | 1,800 | 7,800 |
| | | | Member Months | 3,000 | 7,200 | 7,200 | 6,000 | 23,400 |
| | | Adult Extended Care | Enrollees | 3,113 | 4,350 | 4,350 | 3,263 | 15,076 |
| | | | Member Months | 6,863 | 25,950 | 26,100 | 26,100 | 85,013 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Juvenile Aftercare | Enrollees | 600 | 1,200 | 1,200 | 900 | 3,900 |
| | | Member Months | 2,100 | 8,625 | 9,000 | 8,400 | 28,125 |
| | Re-entry Enhanced Care Coordination | Qualified Enrollees | 12,600 | 16,200 | 16,200 | 16,200 | 61,200 |
| Mental Health | Intensive Service Recipients | Enrollees | 720 | 1,120 | 1,280 | 1,280 | 4,400 |
| | | Member Months | 2,160 | 3,360 | 3,840 | 3,840 | 13,200 |
| | Residential and Bridging Care | Enrollees | 675 | 900 | 900 | 900 | 3,375 |
| | | Member Months | 1,275 | 1,800 | 1,800 | 1,800 | 6,675 |
| | Enhanced Care Coordination | Enrollees | 135 | 180 | 180 | 180 | 675 |
| | | Member Months | 135 | 180 | 180 | 180 | 675 |
| | Kin to peer | Enrollees | 240 | 400 | 400 | 400 | 1,440 |
| | | Member Months | 840 | 4,560 | 4,800 | 4,800 | 15,000 |
| SUD | Substance Use Disorder Engagement, Navigation, & Support | Enrollees | 2,754 | 3,888 | 3,888 | 3,888 | 14,418 |
| | | Member Months | 5,508 | 7,776 | 7,776 | 7,776 | 28,836 |
| Medically Complex | Transitions of Care | Enrollees | 2,295 | 3,240 | 3,240 | 3,240 | 12,015 |
| | | Member Months | 2,295 | 3,240 | 3,240 | 3,240 | 12,015 |
| Perinatal | MAMA's Neighborhood | Enrollees | 432 | 864 | 864 | 864 | 3,024 |
| | | Member Months | 1,512 | 9,288 | 10,368 | 10,368 | 31,536 |

*Estimated Totals do not reflect an unduplicated enrollee count, as enrollees may be enrolled in multiple programs over time.

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Table 2.3b: Summary of program eligibility, service duration, and approaches to avoiding duplication

| Program | Eligibility Criteria<br><br>Note: All must be Medicaid beneficiaries living in LA County) | Average Duration of Services (Months) | Termination/ Discontinuation of benefits | How we will avoid duplication? |
|---|---|---|---|---|
| Homeless High-Risk Population Criteria: | All individuals who are homeless or at risk for homelessness who meet any of the following criteria:<br>- Chronic homelessness<br>- Physical or mental disability<br>- 2+ chronic medical or behavioral health (e.g. mental health or substance use disorder) condition<br>- Recent and/or recurrent acute care utilization (e.g., multiple emergency department visits or hospitalizations for medical or psychiatric issues) | | | |
| Homeless Care Support Services | All adult individuals who meet the Homeless High-risk population | Ongoing, as necessary | Disenrollment if the client leaves housing | Clients enrolled in HCSS services will not be |

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| | criteria who are housed in interim or permanent supportive housing through Housing for Health | | provided through the Housing for Health program, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | enrolled in any other WPC-LA care coordination programs concurrently |
| Benefits Advocacy | All individuals who are homeless or at risk for homelessness who need screening or are eligible for benefits | Until benefits established or completed appeals process | Disenrollment when benefits achieved, or when the client refuses or does not engage in services | Comprehensive SSI and SSDI Benefits Advocacy services will not be provided by any other WPC program |
| Recuperative Care | All adult individuals who meet the Homeless High-risk population criteria who also meet the following criteria:<br>- do not have clinical needs requiring a hospital or skilled nursing facility but for which shelter or homelessness would not reasonably afford the patient an opportunity for sufficient recovery to avoid re-hospitalization.<br>- require short-term, additional support during recovery from an acute illness or exacerbation of a chronic illness | 3 months/ episode | Disenrollment when discharged from recuperative care facility or when 3 month maximum stay is reached | Clients enrolled in the recuperative care program will not be enrolled in any comparable services because recuperative care services will not be provided by any other WPC program |
| Psychiatric Recuperative Care | All adult individuals who are discharged from eligible psychiatric hospitals who also meet the following criteria:<br>- do not have clinical needs requiring a hospital or skilled nursing facility but for which shelter or homelessness would not reasonably afford the patient an opportunity for sufficient recovery to avoid re-hospitalization.<br>- require short-term, additional support during recovery from an acute illness or exacerbation of a serious mental illness. | 3 months | Disenrollment when discharged from psych recuperative care facility or when 3 month maximum stay is reached | Clients enrolled in the psychiatric recuperative care program will not be enrolled in any comparable services because recuperative care services will not be provided by any other WPC program |
| Sobering Center | All individuals who walk-in or are transported to a Sobering Center who are intoxicated, but conscious, cooperative and able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying injuries | 8-23 hours/ episode | Disenrollment when discharged from sobering center facility | Clients enrolled in the Sobering Center program will not be enrolled in any comparable services because Sobering Center services will not be provided by any other WPC program |
| Tenancy Support Services | All adult individuals who meet the Homeless High-risk population criteria who are housed in interim or permanent supportive housing through Housing for Health | Ongoing, as necessary | Disenrollment if the client leaves housing provided through the Housing for Health program, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | Clients enrolled in the Tenancy support services program will not be enrolled in any comparable services because Tenancy support services will not be provided by any other WPC program |
| Re-entry | Adult Jail Referral & Community Referral<br>All adult individuals referred from the county diversion program (pre-booking), probation (supervision), or following release from a correctional | Adult Jail Referral & Community Referral<br>3 months | Disenrollment when handoff to longitudinal community-based providers complete or when client risk is deemed low enough for discharge, or when | Clients enrolled in Re-entry services will not be enrolled in any other WPC-LA care coordination programs concurrently |

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| | facility within 3 months who meet any of the following criteria:<br>- Recent and/or recurrent acute care utilization (e.g., multiple emergency department visits or hospitalizations for medical or psychiatric issues) either before incarceration or while incarcerated<br>- 2+ chronic medical or behavioral health (e.g. mental health or substance use disorder) condition<br>- Serious mental illness (especially those on psychotropic medications)<br>- Substance use disorders (especially candidates for medication-assisted treatment or those with co-morbid mental health or chronic medical issues<br>- Pregnancy<br><br>Adult Extended Care<br>- Individuals who complete 3 months in the Adult Jail Referral or Adult Community Referral program who demonstrate ongoing need for care coordination support | Adult Extended Care<br>Up to 6 additional months | the client refuses or does not engage in services | |
| Juvenile Aftercare | All juvenile individuals referred a juvenile correctional facility, such as a juvenile hall or camp, within 3 months who meet any of the following criteria:<br>- Recent and/or recurrent acute care utilization (e.g., emergency department visits or hospitalizations for medical or psychiatric issues) either before incarceration or while incarcerated<br>- Any chronic medical or behavioral health (e.g. mental health or substance use disorder) condition<br>- Serious mental illness (especially those on psychotropic medications)<br>- Substance use disorders (especially candidates for medication-assisted treatment or those with co-morbid mental health or chronic medical issues<br>- History of involvement with the foster care system<br>- Pregnancy | 6 months | Disenrollment when handoff to longitudinal community-based providers complete or when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | Clients enrolled in Re-entry services will not be enrolled in any other WPC-LA care coordination programs concurrently |
| Intensive Service Recipients (ISR) | All adult individuals with serious mental health diagnosis (SMI) and co-occurring substance use disorders, with 6+ admissions to psychiatric inpatient facilities in 12 months | 3-months | Disenrollment when handoff to longitudinal mental health providers complete, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | Clients enrolled in ISR services will not be enrolled in any other WPC-LA care coordination programs concurrently. |
| Residential and Bridging Care (RBC) | All adult individuals in mental health institutional settings (e.g. psychiatric hospitals or enriched residential services) that meet criteria for functional independence on screening with the Multnomah Community Ability Scale scores | 2-months | Disenrollment when handoff to longitudinal community-based providers complete, when screening establishes that the client is inappropriate | Clients enrolled in RBC services will not be enrolled in any other WPC-LA care coordination programs concurrently |

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| | | | for community mental health care, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | |
| Kin to peer (KTP) | An adult individual with serious mental health diagnosis (SMI) that may include co-occurring substance use disorders, who qualify for the ISR or RBC programs AND have no kin to support them and/or lack appropriate social supports to assist them with recovery and community reintegration | 9 to 12 months (as long as it takes for the client to establish a sustained kin function) | Disenrollment when client has established an enduring relationship that provides them with the kin support needed to achieve personal recovery and pursue community reintegration, or when the client no longer desires to engage in the program. | Clients enrolled in KTP services will not be enrolled in any other WPC-LA programs concurrently. |
| Substance Use Disorder-Engagement, Navigation, and Support (SUD-ENS) | All individuals with active SUD who meet any of the following criteria:<br>- 3 + ED visits related to SUD within the past 12 months<br>- 2 + inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD<br>- 3 + sobering center visits within the past 12 months<br>- Homelessness with SUD<br>- Foster and other at-risk youth in the Department of Children and Family Services' (DCFS) system with SUD<br>- 2+ residential SUD treatment admissions within the past 12 months<br>- 2 + incarcerations with SUD in 12 months<br>- Drug court referral to either a) Sentence Defender Drug Court or b) Women's Re-Entry Court<br>- History of overdose in the past 2 years | 3 months | Disenrollment when handoff to longitudinal SUD providers complete, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | Clients enrolled in SUD-ENS services will not be enrolled in any other WPC-LA care coordination programs concurrently |
| Medically Complex – Transition of Care (TOC) | All adult individuals being discharged from a WPC-LA eligible general acute care hospital who have 3+ inpatient admissions within the past 6 months and meet any of the following criteria:<br>- 1+ avoidable hospital admissions related to a chronic medical problem<br>- Homelessness<br>- Substance use disorder<br>- Mental health disorder<br>- Incarceration within the last month | 1 month | Disenrollment when handoff to longitudinal primary care providers complete, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | Clients enrolled in TOC services will not be enrolled in any other WPC-LA care coordination programs concurrently |
| MAMA's Neighborhood | All expectant mothers who are experiencing risk factors that affect healthy birth outcomes, including:<br>- Homelessness or at risk of homelessness<br>- Physical or mental disability<br>- Chronic medical or behavioral health conditions<br>- Soon to be released from incarceration or recently released from incarceration | 12 months | Disenrollment when handoff to longitudinal community-based providers complete or when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services | Clients enrolled in MAMA's services will not be enrolled in any other WPC-LA care coordination programs concurrently |

## Target Population 1: Homeless High-Risk

For Homeless High-risk programs, WPC-LA will identify individuals (Medicaid beneficiaries) who are homeless or at risk for homelessness who are at the highest risk of decompensation due to medical, psychiatric and/or substance use based on the presence of one or more of the following:

- Chronic homelessness
- Physical or Mental disability
- Two or more chronic medical or behavioral health conditions
- Recent and/or recurrent acute care utilization (e.g. multiple emergency department visits or hospitalizations for medical or psychiatric issues)

Please see Table 2.3b for program-specific eligibility criteria.

Needs assessment: Homelessness is continuing to increase in LAC with an increasing number of those who are homeless also experiencing mental illness and longer periods of homelessness. The Greater Los Angeles Homeless Count for 2016 identified 43,854 homeless people in LAC, a 7% increase since 2015. Seventy-five percent (75%) of these individuals were unsheltered which is a 13% increase from the 2015 Homeless Count. Thirty percent (30%) were chronically homeless which means that they have been homeless for more than a year or have experienced multiple episodes of homelessness. These individuals experience very high rates of illness and disability. Thirty percent (30%) have mental illness, 23% experience chronic substance use, 23% have a physical disability or chronic health condition, and 7% have a brain injury. Eighteen percent (18%) have experienced domestic violence. The demographics of this population are 66% male, 33% female, and 1% transgender; 39% Black/African American, 27% Hispanic/Latino, and 26% White; 8% are less than 18 years of age, 8% age 18-14, 60% age 25-54, 16% age 55-61, and 9% are age 62 and older.[3]

The high rates of homelessness in LAC have resulted in a public health and humanitarian crisis. Studies have shown that living on the streets can take up to 25 years off of an individual's life. People who are living on the streets encounter communicable diseases, exposure to the elements including extreme heat and cold, violence, repetitive exposure to trauma and toxic stress, poor nutrition, etc. Injuries do not heal properly because they cannot be kept clean and individuals do not have a safe and sanitary place to rest and recuperate. Chronic conditions such as diabetes, asthma and high blood pressure worsen as individuals are not able to obtain and store medications properly and maintain treatment regimens. Due to the vulnerable nature of their lives, most individuals who are homeless are forced to focus on daily activities for survival (e.g., food and basic necessities of life) and are unable to prioritize treating their health issues. When they do seek care they often encounter significant barriers such as transportation, appointment wait times, care settings that are not able to accommodate their special needs, etc. Even the best and most coordinated health services are not very effective for individuals who are homeless and whose health is impacted daily by conditions on the street. Health and behavioral health services do not have lasting impact when an individual exits these care settings to return to homelessness on the streets and in shelters.

A 2009 study by the Economic Roundtable estimated that public systems in Los Angeles invest $875 million each year to manage homelessness. This cost includes homeless individuals' use of emergency

3 All data from: 2016 Homeless Count Results, Los Angeles Homeless Services Authority.

rooms, jails, shelters, and other crisis services. The majority of these costs are for health and mental health services including those provided in custody settings. The typical public cost for a homeless person is approximately $3,000 per month. The public costs for the most expensive 10% are over $8,000 per month. This is in stark contrast to the cost for a formerly homeless person who is now housed. The typical public cost for a person in supportive housing is approximately $600 a month.[4]

A 2016 study by the LAC Chief Executive Office on the services homeless individuals use and their associated costs found that costs to public systems have continued to increase. The study focused on services utilized through six County departments: the LAC DHS, DMH, DPH, Public Social Services (DPSS), Probation, and LASD. In FY 2014-2015 these departments spent an estimated combined total of $965 million in providing services, benefits, and care to homeless single adults. Sixty percent (60%) of the estimated spending was for health related services provided by DHS, DMH, and DPH. DHS' average cost per person for the most costly 5% of its patients (n=4,743) was $80,015.[5]

Methodology and collaboration in identifying target population: WPC-LA will address a target population of individuals who are homeless and who have extremely complex health and/or behavioral health conditions. Specifically, WPC-LA will focus on the subset of homeless residents who are the most vulnerable including those who are chronically homeless, who have a disability or chronic health condition, who have a mental illness, and who experience chronic substance use (see eligibility criteria in Table 2.3b).

DHS collaborated closely with other participating entities to define the target population, including DMH, and DPH under the umbrella of the Los Angeles County Health Agency; the Los Angeles Homeless Services Authority (LAHSA); the Housing Authority of the City of Los Angeles (HACLA); and the Housing Authority of the County of Los Angeles (HACoLA). Each of these partners has identified ending homelessness and linking homeless clients to services and resources as a top priority and were partners in development of this WPC-LA program. Each partner brought to the table a deep knowledge of the factors driving homelessness in Los Angeles. Together, using data from the studies cited above, the group was able to come to consensus on the population that would be targeted with the homeless high-risk WPC program. More specifically, our methods involved examining the data as a group and determining the factors that could most quickly lead to stabilization of a large number of high risk, sick homeless individuals. The data demonstrated what the experts had already pointed to: the need for sufficient support services and a strong benefits establishment effort (e.g., SSI advocacy).

Beneficiary identification and outreach: Individuals who meet the WPC-LA criteria (see eligibility criteria in Table 2.3b) will be identified across county by County departments, the Coordinated Entry System, which is a live IT system that tracks and organizes homeless individuals encountered by a wide array of homeless service providers Countywide, and by community-based partners. Patients served by the WPC Homelessness interventions will be Medicaid patients from across the County and not exclusively those served by the County's directly operated health system. DHS will also continue its collaboration with the Los Angeles County Chief Executive Office to identify individuals across multiple County departments (DHS, DMH, DPH, Sheriff, and Probation) who also meet WPC pilot criteria. In addition, DHS will continue its collaboration with the Los Angeles Homeless Services Authority to use the CES to identify the most vulnerable people who are homeless in the County. CES maintains a real time list of individuals

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5 The Services Homeless Single Adults Use and Their Associated Costs: An Examination of Utilization Patterns and Expenditures in LAC Over One Fiscal Year

experiencing homelessness and matches them to housing resources and services that best meet their needs. CES is described in more detail in Section 3.2. Finally, community partners will refer clients to WPC-LA using a point of care eligibility tool.

Number of beneficiaries to be served: WPC-LA is projected to enroll more than 30,000 – 35,000 homeless clients annually. Clients will be matched to WPC-LA program components based on their individual needs. Some individuals will access all program components and some will access a subset. The WPC-LA program components are described in detail in 3.1. We estimate that annually 5,000 – 8,000 clients will be served by Homeless Care Support Services, 20,000 by Countywide Benefits Advocacy, 1,750 per year by Tenancy Support Services, 24,000 to 32,000 encounters annually for a Sobering Centers, and 5,000 by Recuperative Care Centers. Each program has a capacity limit due to funding and resource limitations (i.e., housing supply). All individuals served under WPC-LA will be Medi-Cal beneficiaries. WPC-LA services will be provided countywide.

### Target Population 2: Justice-involved High Risk

For justice-involved high risk programs, WPC-LA will identify individuals (Medicaid beneficiaries) who are at the highest risk of medical, psychiatric and/or substance use decompensation based on the presence of one or more of the following:

- Recent and/or recurrent acute care utilization (e.g., multiple emergency department visits or hospitalizations for medical or psychiatric issues) either before incarceration or while incarcerated
- Multiple and/or complex chronic medical conditions identified at or around the time of intake (e.g., HIV, diabetes)
- Serious mental illness (especially those on psychotropic medications)
- Substance use disorders especially those who are good candidates for medication-assisted treatment or those that have co-morbid mental health or chronic physical health issues
- Pregnancy

The WPC Re-entry pilot will target justice system-involved, Medicaid-eligible individuals who are at the highest risk of deterioration from chronic medical and/or behavioral health conditions during the period of reentry into the Los Angeles County community from custody. We will identify these individuals just prior to release from custody or in the days following release through referrals from community partners. The project will support the successful transition of clients during re-entry from LAC jails or California Department of Corrections and Rehabilitation (CDCR) facilities, Juvenile Halls, or following release to the community by courts pre-sentencing.

Needs assessment: Currently, medically high-risk and acutely ill patients incarcerated in county jails or state prisons, or juvenile halls receive few re-entry services. Reach by community-based service providers is limited and state prisons have few resources to link patients to services in the community. Inmates are released only to struggle with obtaining medical coverage via Medicaid, restart medications they had been on while in custody and connect to community based providers who are able and willing to follow them longitudinally, and they struggle to obtain necessary social support services when they return to the community. For those with chronic medical conditions, psychiatric conditions, or substance use disorders, this lack of support upon re-entry translates into deterioration of their existing medical and psychiatric conditions, and avoidable utilization of emergency departments and preventable hospitalizations. Low literacy levels, a high prevalence of repetitive trauma, unfamiliarity

with the health delivery system, lack of self-efficacy, and a return to unsafe and chaotic home environments and homelessness compound the challenges. These issues can be compounded further among youth who need greater support as they navigate the critical transition between childhood and adulthood, help with family integration, and treatment that breaks the cycle of cumulative trauma and encourages personal development into meaningful roles in the community. Expansion of re-entry services will better support the most vulnerable and sickest patients effectively transition back to community-based health and social support systems. This effective transition will help prevent unnecessary and expensive acute care utilization, reduce morbidity and mortality, and reduce recidivism.

The potential adult target population from which to draw is large: LAC jail for adult releases between 350 and 500 individuals each day. 50 individuals each day are classified as medically high-need based on their acute and chronic conditions, 90 per day have moderate to serious mental illness and nearly 300 per day have a significant substance use disorder. Each day, on average 2 pregnant women and 10-15 individuals who are HIV positive are released. All in all, the LAC jail is not only the largest jail in the world, it may also be one of the most important places in America to engage sick, underserved Medicaid eligible individuals at the point of release who are at risk for significant and rapid health deterioration. The LAC jail is not the only setting that releases high volumes of individuals to LAC. California's CDCR sends home approximately 13,000 individuals to Los Angeles County each year. Of these State prison parolees, 1,800 are in the Enhanced Outpatient Program due to serious mental illness and/or because they meet criteria as medically high risk (four or more chronic medical conditions, over age 65, more than 13 prescribed medications, or multiple hospital admissions). Finally, LA County, the home of largest Juvenile justice system in the country, releases 500-650 youth from juvenile institutions each month. Approximately, 40% of these clients have suspended Medi-Cal that is re-instated upon release. Together the jail, prison, and juvenile institution returnee populations create a large pool of potential WPC-LA Reentry program enrollees. The capacity limits of the proposed programs are due to challenges from organizational capacity and staffing issues within the community. If through PDSA cycles and other process improvement efforts program expansion is warranted, WPC-LA will pursue such expansion.

Methodology and collaboration in identifying target population: To craft the vision for the program and identify the target population, DHS partnered with a number of departments and organizations. Key partners included the LASD, LAC Superior Courts, LAC Probation, LAC DPH, LAC DMH, L.A. Care and Health Net Health Plans and the Los Angeles Regional Reentry Partnership (LARRP).[6] Dr. Shira Shavit, the Executive Director of the Transitions Clinic Network, a nationally recognized leader in reentry models, and Dr. Clemens Hong, a DHS physician lead for WPC-LA and co-founder of the Transitions Clinic Network, participated in the reentry workgroup. The focus of the group was on ensuring that justice involved adults re-entering from custody have care coordination support following release and are well prepared to return to their communities with clear plans (e.g. assessments completed and connections made to community-based care coordination teams and providers) prior to release. The Deputy Chiefs of Juvenile District Services and Juvenile Institutions identified the underserved areas of the justice-involved juvenile population and developed a five-step system that screens, assesses, processes, transitions, and cares for high-risk youth from detainment to integration back into the community.

Beneficiary identification and outreach: Individuals eligible for the re-entry intervention will be identified at a number of entry points throughout Los Angeles County, including at the time of release

[6] LARRP is a network of over 120 community organizations, faith based organizations, public agencies, advocates and other community stakeholders working on successful reintegration of formerly incarcerated people into communities in LAC.

from LAC jails, LAC courts, State Prison and LAC Juvenile Institutions. From LAC jail, individuals identified by jail health staff will be referred via warm handoffs to WPC enrollment teams stationed just outside the jail. LAC courtrooms with historically high volumes of cases of defendants with serious mental illness or substance use disorders will host WPC-LA reentry program enrollment teams to assist with immediate engagement and enrollment into the project. With CDCR, LAC will build on existing partnerships to create a warm handoff at the time of release so when paroles arrive in LAC they can be supported by the WPC-LA re-entry project staff. In the Juvenile Justice System, Aftercare Transition Deputies will identify youth in the juvenile hall/camp based on clinical and program eligibility criteria.

At each point of entry, dedicated WPC-LA re-entry program staff will use a point-of-care risk assessment tool that uses medical, psychiatric, and social factors to identify and evaluate potential candidates for program eligibility, including Medi-Cal eligibility and presence of inclusion criteria as listed above. If eligible for the program, staff will assess the client's interest in participating and link interested clients with the appropriate WPC re-entry team member for further engagement. We will identify and work with individuals as early as possible, but individuals will only be formally enrolled in WPC-LA in the community following release from custody.

Number of beneficiaries to be served: The WPC-LA community re-entry intervention will target 1550 new individuals each month. We will target April of PY2 as the Re-entry program start date. All enrollees will be Medi-Cal beneficiaries. We anticipate that of the 1,250 monthly enrollees approximately 900-1,000 will come through jail referral (e.g. after release from the county jail system), and 450-550 will be engaged through community referral through self-referral, referrals from the courts, California Department of Corrections and Rehabilitation ("CDCR") or Community Based Organizations ("CBOs"). Additionally, we will provide an additional 6 months of extended care for 25% of the highest risk clients in the jail and community referral programs. Over 4 years, we will provide 275,663 member months of services for adults upon re-entry. The program will be capped due to capacity and financial constraints. For the juvenile justice population, we will provide 28,125 member months of services.

For the re-entry intervention, we will use PDSA to right-size the program over time as well as determine if we should pursue any stratification of the population. This will include tiering to different lengths of participation based on acuity and needs (e.g., some enrollees may benefit from more or less than the standard days of support. Through an extended care program, we will provide an additional 6 months of services to approximately 25% of the highest risk adults and juveniles. This will result in an average of 90-days follow-up for lower risk adults and 180 days for low risk juveniles; and 270 days follow-up for higher risk adults and 365 days for the highest-risk juveniles in the community re-entry program. In the case of pre-arraignment, pre-sentencing, and CDCR high-risk populations, we will use this pilot to test processes and the effectiveness of Re-entry interventions and consider expansion in subsequent years.

### Target Population 3: Mental Health High-Risk

Three WPC-LA programs will focus on the mental health high-risk target population: Intensive Service Recipient (ISR), serving high-utilizers of mental health system resources; Residential and Bridging Care (RBC), serving individuals in locked inpatient/IMD or enriched residential settings who may be able to be transitioned to community-based placements; and KTP which will provide additional support through community health workers that develop a close, long-term relationship with the client. Program eligibility is described separately in the section below.

Intensive Service Recipient (ISR)

The Mental Health Intensive Service Recipient (ISR) program proposes to serve adults with serious mental health and co-occurring substance use disorders, with frequent admissions to psychiatric inpatient facilities. These will be adults who have:

- A severe mental health (SMI) diagnosis, which could include individuals with a history of homelessness, substance abuse, medical condition and/or incarceration; and
- A minimum of 6 psychiatric hospital admissions in the previous year.

Needs Assessment: Individuals with SMI who have multiple psychiatric hospital admissions need intensive care support services in order to access the appropriate level of services. This population tends to access services in an episodic and crisis-oriented manner, rather than on a consistent, ongoing basis. There tends to be high utilization of psychiatric inpatient services, often due to a lack of connectedness to behavioral health, physical health, and community services. These individuals could more effectively access integrated behavioral health, physical health, and substance use disorder services in community-based settings rather than in hospital settings. Intensive aftercare transition planning would help to alleviate these challenges and result in better access to the appropriate level of care, as well as improved coordination and collaboration between agencies.

The lack of temporary and permanent supportive housing is an additional challenge to the stabilization of the proposed ISR population, limiting the ISR team's ability to effectively house and provide the appropriate level of supportive services following psychiatric hospitalization. Oftentimes the absence of housing options results in hospital stays that are longer than what is needed to address an individual's mental health issues, resulting in additional costs to the service delivery system.

Once the individual is home or returns to the community, he or she may have additional needs related to completing activities of daily living, maintaining treatment and medication compliance, money management, transportation, and linkage to other community resources for basic necessities such as food and clothing. These are all fundamental needs for the person's recovery and for living successfully in the community.

Methodology and collaboration in identifying target population: The executive leadership teams of DMH, DHS, and DPH's Substance Abuse Prevention and Control (SAPC) collaborated to identify the target population and eligibility criteria for the program to assure that those with the greatest need would be served. Following a joint examination of available data on inpatient and emergency department utilization, the leads of the three departments agreed on the threshold criteria that would make an individual eligible for the program (six or more psychiatric hospitalizations in the last 12-month period). At the time of their review these totaled 755 individuals.

Number of beneficiaries to be served: After review of available data, the partners agreed to focus on the highest utilizing individuals, defined as those with six or more psychiatric hospitalizations in the last 12-month period. With this threshold, it is estimated that a total of 4,400 Medi-Cal beneficiaries will be served through this program. The goal of the program when it is fully running will be to serve up to 1,020 individuals per year. Over the course of the WPC-LA program, 13,200 member months of service. The enrollment cap is due to the intensity and availability of resources to connect clients to during and at the end of the average enrollment period (e.g., housing).

Beneficiary identification and outreach: Individuals will be identified in County and FFS inpatient psychiatric units, and connected to the ISR program in their SA. A member of the ISR team will serve as the hospital liaison and will secure reports from the DMH Mental Health Management Information System (MIS) to identify eligible clients. The ISR program will provide intensive outreach and engagement services to the target population to encourage participation in the program.

Residential and Bridging Care (RBC)

The Residential and Bridging Care (RBC) program proposes to serve adults with serious mental illness (SMI) and co-occurring substance use disorders in psychiatric inpatient units, exiting Institutions of Mental Disease[7] (IMDs) and being treated in enriched residential settings[7] (ERS) that also meet criteria for functional independence on screening using the Multnomah Community Ability Scale and who can be rapidly and effectively returned to non-institutional settings if they receive appropriate services and supports to facilitate their reintegration into the community.

While IMDs and ERSs are appropriate for individuals who require additional intensity of services and supports beyond that available in other settings, or for specialized populations such as those with complex medical needs or histories of criminal justice involvement, a portion of the IMD and ERS populations would not require these services if appropriate planning and community supports were available. They are, however, a challenging-to-place population: many have a history of poor adherence to treatment, have failed prior board-and-care placement, and are homeless or at risk for homelessness upon release from institutional settings. Although many patients in institutional settings have clinical needs that require care be delivered in a locked setting, many individuals with SMI receive care in a setting that is not best suited to their current needs or functioning because there are no available community placements to which the patient can safely return. Because of both the resources expended on institutionalizing these patients, the direct impact on the patient of keeping them in a more restrictive setting than they might otherwise require, and the downstream effects on the medical and psychiatric delivery system (e.g., ED overcrowding), these patients are an important population for focus of WPC-LA.

Needs Assessment: There are over 2,000 patients in psychiatric inpatient beds, 1,032 patients in IMD beds, and 600 patients in ERS across LAC on any given day. At each level, patients are "stuck", unable to freely flow between levels of care when clinically ready due to a shortage of capacity.

- Approximately 40% of patients in inpatient psychiatric beds could be discharged from the hospital if an appropriate placement, often an IMD or ERS, were readily available. This, in turn, renders the bed unavailable for use by a patient with a genuine acute need.
- Approximately 25% of patients in an IMD are stable enough for discharge if there were sufficient social supports and resources and community placements able to help reintegrate a patient with stable but significant mental illness.
- Approximately 25% of patients in an ERS could transition to independent living if appropriate housing and supportive services and housing were available.

Currently, the LAC average length of stay in an IMD bed is just under 18 months, meaning that each year only 600 of the total 1,032 IMD beds available within the County can be expected to turn over, or 50 per

[7] ERSs are supportive non-medical residential programs that serve individuals ready for discharge from IMDs and acute inpatient units. They offer housing, specialized mental health treatment programming, augmented residential supervision, and have the capacity to manage emergencies 24 hours per day 7 days per week.

month. This slow transition of patients out of IMDs limits the movement of patients from acute psychiatric hospital beds, which in turn leads to overcrowding in medical and psychiatric emergency rooms and other psychiatric crisis stabilization facilities by patients who require inpatient admission.

In a county where inpatient psychiatric beds, IMD beds, and ERS placements are at a premium, taking steps to foster and catalyze community reentry is a vital strategy for expanding the reach of these limited resources. Specifically, the following are needed: (a) housing options; (b) navigation supports; (c) peer counseling to work on behaviors necessary to function outside the institution; (d) transportation to services; (e) organizational and financial management supports; and (f) food and clothing. By focusing on this target population of institutionalized individuals who could be placed in the community if the appropriate patient-specific resources and supports could be established, this pilot program aims to improve timeliness and quality of community reintegration of institutionalized individuals with SMI, as well as the system's ability to move individuals through all required levels of care.

Methodology and collaboration in identifying target population: DMH and DHS, armed with data from the public and private safety net hospitals, collaborated to examine the target population based on utilization and length of stay in locked or clinically enriched facilities. Based on the following assumptions the target population was narrowed:

- There are over 3,000 patients in inpatient psychiatric beds and IMDs in LAC, approximately 75% (~2,300) of whom are Medi-Cal eligible.
- There are 600 persons in ERS programs, approximately 70% (400) are Medi-Cal eligible.
- Approximately 50% of clients may have their mental health issues sufficiently stabilized to the point that there could be consideration of community-based placement.

Within this cohort of potentially eligible individuals, the specific program beneficiaries will be more precisely selected based on provider/clinical team assessments of the individual's preparedness for discharge. Patients with strong "likelihood to be discharged" will be enrolled in the pilot population, as will individuals for whom an IMD or ERS placement has been requested.

Number of beneficiaries to be served: Expected total enrollees will be 3,375 over the course of 4 years. Given a two-month average enrollment, about 6,675 patient-months will be provided in the program. Enrollment will be capped at 675 individuals in Year 2 and 900 each year afterwards; all program participants will be Medi-Cal eligible given the finite number of community placements available. We estimate that 40% of enrollees will come from inpatient units, 40% from IMDs and 20% from ERS settings.

Beneficiary identification and outreach: A regional DMH team will work with teams in hospitals with acute psychiatric units, IMDs, and ERS to identify individuals who are candidates for an initial assessment to determine whether a particular individual may be ready for discharge and what each client needs to be ready for discharge. Once potentially eligible clients have been identified, these staff will inform the Residential and Bridging Care (RBC) Transition Team, who will then contact the individual or their conservator, as appropriate, to work on the aftercare plan and begin the process of transitioning the client to community-based services. Because WPC funds cannot be used for services provided within an IMD facility, we anticipate those exiting the IMD will require enhanced care management support once in the community to achieve stabilization.

Kin to peer (KTP) Program

Needs assessment: The "Kin to peer" (KTP) program will serve clients who are eligible for the Los Angeles County Department of Mental Health (LACDMH) Intensive Service Recipient (ISR) or Residential and Bridging Care (RBC) programs who lack family or healthy social support systems. These clients suffer from a serious mental illness (SMI) and languish in the context of extended stay in residential facilities or regular transitioning in and out of psychiatric ERs/Hospitals. While the lack of access to housing as well as chronic medical problems, co-morbid substance use disorders, and a myriad of psychosocial stressors drive these problematic phenomena, a lack of healthy relationships are core to the problem. As such, KTP clients would benefit tremendously with ongoing support from a peer, substituting as family, to provide a surrogate "kin" function. The subset of individuals that lack this "kinship" will be referred from the ISR and RBC programs into the KTP program for ongoing support after their discharge from these programs.

Methodology and collaboration in identifying target population: We will use the pre-existing methodology, referenced in the ISR and RBC sections above, to identify candidates who lack family or health social support systems for the KTP program.

Number of beneficiaries served: The KTP program will reach out to a subset of the ISR and RBC program clients to identify 400 of the highest-need recipients of WPC-LA services that would also benefit from longer-term, peer navigator services to act as support kin.

Beneficiary identification and outreach: Individuals will be identified by ISR and RBC team members and referred to the KTP program.

### Target Population 4: Substance Use Disorder (SUD) High-Risk

LAC-DPH Division of Substance Abuse Prevention and Control (SAPC) will lead the Service Planning Area (SPA)-based WPC-LA SUD Services Engagement, Navigation and Support (SUD-ENS) program, targeting specific high-risk Medi-Cal beneficiaries with SUD and at least one of the following eligibility criteria:

- 3 or more ED visits related to SUD within the past 12 months
- 2 or more inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD
- 3 or more sobering center visits within the past 12 months
- Homeless (meeting HUD criteria) and SUD
- Foster and other at-risk youth in the Department of Children and Family Services' (DCFS) system and SUD
- More than 2 residential SUD treatment admissions within the past 12 months
- History of 2 or more incarcerations with drug use
- Drug court referral to either a) Sentence Defender Drug Court or b) Women's Re-Entry Court
- History of overdose in the past 2 years

Needs assessment: Historically, low income individuals in LAC with SUDs had limited access to SUD treatment services for three reasons: a) low income people with SUDs were typically not eligible for Medicaid, b) even when eligible, few SUD services were covered by Drug Medi-Cal, and c) there was not an SUD organized delivery system (ODS) in Los Angeles County. With the advent of the Medicaid expansion of the ACA and approval of California's Drug Medi-Cal (DMC) 1115 Waiver, individuals with low income have expanded access to SUD services. In the face of these historical access issues, individuals with SUD, who have a high prevalence of low health literacy, adverse childhood events and

cumulative trauma, co-occurring mental illness, and numerous social needs, have worse health outcomes, including a dramatic reduction in life expectancy, and higher utilization of costly acute health services than those who do not have SUD.[8]

Because of historical unmet need among the Medi-Cal population with SUD, and the opportunity to capitalize on new treatment services in the DMC waiver, LAC will focus a portion of WPC-LA on ensuring that current high utilizers and high-risk patients with SUD are proactively engaged to increase utilization of DMC services. By identifying, engaging, and providing navigation and support services to individuals with SUD who are not actively engaged in LAC's DMC-ODS, WPC-LA will improve access and remove barriers to effective SUD care in Los Angeles County, making optimal use of the services newly available under DMC-ODS.

Methodology and collaboration in identifying target population: The criteria defining the target population for the SUD-ENS pilot were developed through review of high risk and high utilizing groups with SUD who have difficulty initiating and completing SUD treatment, and who experience disproportionate negative health, social, and criminal justice outcomes. SAPC reviewed the top 10% of patients receiving SUD treatment dollars during the last three fiscal years (FY12-15) who had three or more residential services or two or more residential detoxification services during the last fiscal year (FY14-15), which is considered to be avoidable residential treatment. This analysis found that high utilizers were disproportionately likely to be unemployed, homeless, or have a physical or mental health problem. A health plan partner analysis also found high rates of SUD diagnoses in inpatient (IP) and emergency visits by its homeless members.

To augment the analysis, the WPC-LA team also received qualitative input from partners with extensive experience serving the potential target population, including the LAC Superior Courts, the LAC Drug Courts, health plan partners, LAC DMH and LAC DHS, as well as many of the contracted safety net SUD service providers in LAC. The final criteria reflect overall WPC-LA priorities, which include supporting programs for high utilizers of health services, justice-involved populations and those experiencing homelessness.

Beneficiary Identification and outreach: The identification of SUD-ENS program participants will require both data-mining of countywide data systems and health plan data, and as referred at the point of care by participating providers from sites across LAC, including public and private hospitals/EDs, community sites, and courts. The relative role of each in identifying program participants is expected to vary based on the specific subpopulation and inclusion criteria. A summary of these data sources and referral sources is included below, by inclusion factor.

| Inclusion factor | Potential Data Source | Referral Source |
|---|---|---|
| 3+ ED visits related to SUD within the past 12 months | • Health plan claims<br>• LANES | • Identified by ED staff prior to discharge |
| 2+ inpatient admissions within the past 12 months for physical and/or | • Health plan claims<br>• LANES | • Identified in hospitals prior to discharge |

8 Westman J et al. Mortality and life expectancy of people with alcohol use disorder in Denmark, Finland and Sweden. Acta Psychiatr Scand. 2015 Apr;131(4):297-306.

| | | |
|---|---|---|
| mental health conditions and co-occurring SUD | | • Identified by health plan or provider group concurrent review |
| 3+ sobering center visits within past 12 months | • Sobering Center EHR queries | • Identified by sobering center staff |
| Homeless (meeting HUD criteria) and SUD | • N/A | • Hospitals<br>• Identified in homeless encampments by outreach workers<br>• Drop in programs or shelters |
| Foster and other at-risk youth in the DCFS system and SUD | • Foster medical hubs EHR queries | • Identified by DCFS staff, DCFS service providers, and foster medical hubs |
| More than 2 residential SUD treatment admissions within the past 12 months | • SAPC data collection system: Los Angeles County Participant Information System (LACPRS) | • Identified by SUD residential treatment providers |
| History of repeated incarceration (2+)—with drug use | • N/A | • Identified by Probation, Drug Courts, and SUD providers |
| Drug court referral to either a) Sentence Defender Drug Court or b) Women's Re-Entry Court | • N/A | • Identified by Drug Court staff, Probation Officers |
| History of overdose in past 2 years | • Health plan claims | • Identified in hospitals prior to discharge |

For individuals identified through data queries/mining efforts, the SUD-ENS team will aggregate and review results and identify an eligible cohort on a regular basis, initially anticipated to be quarterly. To facilitate direct referral from points of care, SAPC will educate its contracted SUD provider network and other partners on the SUD-ENS program and target population criteria. This will enhance provider collaboration in identifying qualifying beneficiaries. In addition, SAPC will launch a series of workgroups with the additional partners listed above (Drug Courts, Probation, DCFS, public and private hospitals, health plans, and homeless service providers) to develop screening tools and workflows to assist staff in identifying and referring beneficiaries to SUD-ENS outreach and engagement workers. As with all WPC-LA programs, individuals must choose to opt in to the SUD-ENS.

Number of beneficiaries to be served: The Technical Assistance Collaborative estimated that 8.15% of youth and 8.83% of adults in Medi-Cal have SUDs.[9] LAC plans to target the top 10% of those with SUD for SUD-ENS, which is an eligible population of approximately 23,700 individuals.[10] However, the total size of the target population is capped 720 participant caseload per month, 100% of whom will be Medi-

9 Technical Assistance Collaborative and Human Services Research Institute, "California Mental health and Substance Use System needs Assessment", February 2012.
10 Conservative estimate, based on 2,960,693 Medi-Cal beneficiaries in LA * 8% w/SUD * 10% highest utilizer/risk = 23,685 total in LA.

Cal recipients. A percentage of these individuals will have multiple encounters with the program so this is considered a duplicated count. In Year 3, Year 4 and Year 5 we anticipate that 3,888 enrollments will be served. In Year 2, because of ramp-up time, a total of 2,754 will be served. It was necessary to establish an enrollment cap for SUD-ENS that is reflective of both SAPC's expected capacity to provide a short duration, high quality, robust intervention and also the capacity of its developing ODS provider network.

### Target Population 5: Medically Complex – Transitions of Care (TOC)

The medically complex Transitions of Care (TOC) program proposes to serve adults Medi-Cal beneficiaries admitted to a Lanterman-Petris-Short (LPS) Act-designated general acute care hospital who are on the LANES HIE with three or more admissions (medical or psychiatric) within the last 6 months, and at least one of the following:

- One or more avoidable hospital admissions related to a chronic medical problem
- Homelessness
- Substance use disorder
- Mental health disorder
- Incarceration within the last month

Needs Assessment: According to the Agency for Healthcare Research and Quality less than 1% of patients in the U.S. utilize more than 22% of health care spending, with an average of $90,000 per patient.[11] These individuals have multiple or severe chronic medical problems and complex medication regimens that create challenges for patients and their health care teams. Among Medicaid beneficiaries, co-occurring behavioral health issues and significant social needs such as homelessness compound these issues. These vulnerable patients are at high risk for poor outcomes upon discharge from inpatient medical facilities.

Patients are most vulnerable and at risk for poor outcomes and hospital re-admissions in the four weeks following a hospital discharge. Even with greater recent investments in care transitions support by hospitals and health plans, patients too often leave the hospital with confusion about their medication regimens and their follow-up plans. Medi-Cal beneficiaries, in particular, face many other issues including co-occurring behavioral health issues and social service needs. When these patients return to the community, they frequently have needs that were not sufficiently addressed prior to discharge, including the need for durable medical equipment or home health supports, money management support, transportation support, and links to community resources, among others. These unmet needs greatly impact their ability to recover from their illness, and may result in poor health outcomes, emergency department visits, or readmissions.

Methodology and collaboration in identifying target population: We convened a TOC workgroup that included representatives from health plans, primary care providers, social work providers, and community-based partners, including Partners in Care, a non-profit organization that has decades of experience providing community-based TOC interventions for clients countywide. The workgroup collaboratively developed the intervention and suggested patient selection criteria. The workgroup looked at the literature on transitions of care interventions within the safety net including literature on

11 The High Concentration of U.S. Health Care Expenditures, Research in Action, Issue 19. Agency for Healthcare Research and Quality. http://archive.ahrq.gov/research/findings/factsheets/costs/expriach/#MostExpensive

the following programs – Project RED, Project BOOST and the IMPaCT Model.[12] The workgroup also examined available local health plan data on general acute hospital admissions. The data run completed looked at the Medicaid managed care population based on various data cutoffs of number of admissions per patient. Specifically, L.A. Care data was pulled based on a criteria narrowing on type of hospital – acute care with psychiatric emergency room capacity – and narrowing on number of admissions per patient in past 12 months. With the literature and data in hand, the workgroup pursued detailed discussions on how to best target the highest-risk medically complex Medicaid population in LAC. Leaders from DHS, DMH, and L.A. Care decided that target patients for the program would have three or more admissions to medical or psychiatric hospitals within a six-month period. It was estimated that approximately 5,500 L.A. Care members met the program admissions criteria in the last year. The workgroup selected more than three admissions to medical or psychiatric hospitals in the past six months as the criteria for the WPC-TOC program based on (a) resources available for this program with WPC-LA which force us to limit the maximum size of the target population to about 300 enrollees per month and (b) where the literature demonstrates an impact on readmissions and safe integration into to the community can be made in high risk Medicaid populations. The group then identified additional qualitative risk factors (e.g., homelessness, SUD) that could be used to identify a population that would be amenable to interventions planned through the TOC program. Because of the need to locate staff at the site of acute care facilities, the number of hospitals participating in the pilot was narrowed to LPS-designated hospitals that serve a disproportionately high number of individuals that are high-users of multiple systems. Because data from multiple systems is required to identify patients, the leadership group also required that the hospital be on the LANES HIE. This requirement will allow patient identification and tracking to be manageable.

Beneficiary identification and outreach: Individuals meeting admissions criteria will be identified using data from the LANES Health Information Exchange and DHS and health plan electronic data repositories. The WPC-LA team will work with the hospital care team to identify the subset of these patients that meet the additional selection criteria described above. Initially, we anticipate that the WPC-LA team will need to perform point-of-care (POC) screening to determine eligibility. They will develop these POC tools for use by WPC-LA teams, but make them widely available to staff in the hospitals in order to encourage appropriate referrals. In subsequent years, we anticipate having the ability to identify eligible clients through improved data analytics approaches. If the patient agrees to participate, the TOC team will match the client with a CHW, who will meet with the patient in the hospital.

Number of beneficiaries to be served: We will provide up to 3,240 transition-of-care contacts per year to individuals who meet patient selection criteria. Some individuals will receive multiple contacts if they have recurrent hospital admissions. We will have an enrollment cap of 300 patients per month, which will be the caseload capacity for each team.

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12 Jack BW, Chetty VK, Anthony D, Greenwald JL, Burniske GM, Johnson AE, Forsythe SR, O'Donnell JK, Paasche-Orlow MK, Manasseh C, Martin S, Culpepper L. A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. Annals of Internal Medicine.
J Am Geriatr Soc. 2009 Sep;57(9):1540-6. Epub 2009 Aug 18. A quality improvement intervention to facilitate the transition of older adults from three hospitals back to their homes. Dedhia P, Kravet S, Bulger J, Hinson T, Sridharan A, Kolodner K, Wright S, Howell E.
Kangovi S, Mitra N, Grande D, White ML, McCollum S, Sellman J, Shannon RP, Long JA. Patient-centered community health worker intervention to improve posthospital outcomes: a randomized clinical trial. JAMA Intern Med. 2014 Apr;174(4):535-43. doi: 10.1001/jamainternmed.2013.14327.

## Target Population 6: MAMA's Neighborhood

For High Risk Expectant Mothers, MAMA's Neighborhood (MAMA's) program will identify those women who are experiencing risk factors that affect healthy birth outcomes including:

- Homeless or are at risk for homelessness,
- Physical or mental disability,
- Chronic medical or behavioral health condition,
- Soon to be released from incarceration or recently released from incarceration

Existing programs that provide community-based services, including home-visitation programs such as Nurse Family Partnership (NFP), have been unable to meet the needs of LA women largely due to restrictive eligibility criteria, limited geography and scope and insufficient capacity. The County of Los Angeles Board of Supervisors has recently noted the importance of meeting the needs of pregnant women through a board motion calling for a comprehensive review and plan for improvement of home-visitation services.

Through WPC, MAMA's seeks to address this priority and fill the gaps in services with concentration on those women of childbearing age who are also part of the aforementioned high risk populations. MAMAs will provide wraparound prenatal services to women experiencing concurrent, social, behavioral and mental health risk factors that impact birth outcomes.

Needs Assessment: The US Census documented an average of 132,000 births annually in LA County between 2012 and 2015. Strong Start – a federally funded national demonstration project for which DHS was a grantee – implemented a three-year intervention (2014-2016) to improve healthy birth outcomes, specifically reducing preterm births and low birth weights that exceed national averages. Local Strong Start activities within LAC DHS hospitals, referred to as MAMA's Neighborhood, provided pregnant women comprehensive prenatal services that emphasized care coordination and care planning that integrates the physical, social, behavioral and mental health needs of clients. The intake assessment guided patient risk stratification and subsequent care coordination. Patients received enhanced clinic-based services including: 1:1 contact with their assigned care coordinators and social workers and a full range of prenatal and postpartum care at scheduled intervals based on the risk assessment and individualized care plan.

Based on our knowledge of MAMA's highest risk patients, additional services are needed beyond that which are available in standard prenatal clinic settings. Strong Start, MAMA's high-risk patients, reported resource instability (housing, food, income); alcohol, tobacco and drug use; and trauma among other risk factors. Food scarcity was common despite WIC access at 42%. Substance use was common with 42% engaging in drug use while pregnant. Intimate partner violence (IPV) was exceptionally high at 79%, and 69% of the patients needed further mental health assessment and treatment based on their depression and anxiety scores. Risk factors are simultaneous and urgent in the population; 22% reported three concurrent risk factors during their prenatal intake and 10% reported four.

Methodology and collaboration in identifying target population: Vital to the MAMA's Neighborhood demonstration was its Network of service agencies prepared to help pregnant women with their range of social, health and mental health needs. In discussion with these Neighborhood Network partners, we have identified many of the gaps in existing programs as well as which populations are most challenging

to engage in care and/or have the most limited access. Through these community engagement exercises and ongoing conversations, we have jointly developed the WPC-MAMAs model to specifically address the unmet need for services in the prenatal service community.

Beneficiary identification and outreach: We will identify beneficiaries through clinical and non-clinical encounters. Clinical sites include prenatal care clinics. Non- clinical sites include Emergency Departments, homeless outreach teams, domestic violence shelters, jails and other agencies servicing women of childbearing age. Screening for program eligibility will employ the prenatal assessment currently in use within the MAMA's neighborhood program. This survey is comprised of validated tools assessing the social determinants of health as well as mental/behavioral health. Scoring of these scales and risk stratification will be automatically generated through a web-based platform at intake and the WPC initiative will target the highest risk level group. Enrollment to the MAMA's WPC program will provide wraparound perinatal services by mobile care teams (MCT).

Number of beneficiaries to be served: MAMA's teams working throughout the LA County SPAs will serve approximately 3,024 pregnant women over four years.

## 3.1 Services, Interventions, and Care Coordination

Each WPC-LA program addresses the needs of the identified target population through the thoughtful application of a discrete set of tools defined in the WPC Toolkit (see Section 2.1), each tool used in different ways and in different combinations to meet the needs of each program's target population. Table 3.1a, below, summarizes how the Toolkit is used across our ten WPC programs. A multidisciplinary team of individuals with robust expertise in serving each target populations developed each of these programs. They understand how services have supported the population to date and recognize how gaps in current services, including lack of service integration, has historically led to suboptimal patient outcomes. The application of the Toolkit will narrow these often longstanding gaps in the care-services continuum by introducing new innovations and by bringing entities closer together through convening and engagement to reduce costs, reduce reliance on costly acute services and, ultimately, improve the target populations' overall health and wellbeing.

Table 3.1a: Use of Toolkit across WPC-LA Programs

| Target population | Program | Care Support and Coordination | Mobile Health Care Support Teams | Connection to Clinical Services | Direct Provision of Non-Medical Reimbursable Clinical & Support Services | Physical Infrastructure | Training & Performance Improvement | Use of New Workforce Members | Outreach & Engagement | Housing Support Services | Enabling Services | Care Management Platform | Other IT Solutions | Countywide Data Integration |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Homeless High Risk | Homeless Care Support Services | ✓ | | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Benefits Advocacy | | ✓ | | | | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ |
| | Recuperative Care | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Psychiatric Recuperative Care | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Sobering Center | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| | Tenancy Support Services | ✓ | | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Justice-involved High Risk | Community Re-entry: Adult Jail Referral | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Community Re-entry: Adult Community Referral | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Community Re-entry: Adult Extended Care | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Community Re-entry: Juvenile Aftercare | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Enhanced Care Coordination Re-entry | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mental Health High-Risk | Residential and Bridging Care | ✓ | | ✓ | | | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ |
| | Intensive Service Recipient | ✓ | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | ✓ |
| | Kin to peer | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| SUD High-Risk | Substance Use Disorder-Engagement, Navigation and Support | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medically Complex | Medically Complex-Transition of Care | ✓ | | ✓ | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Perinatal High-Risk | MAMA's Neighborhood | ✓ | | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

Several tools are used across multiple projects. Specifically, the Care Management IT Platform (CMP) is the backbone of WPC-LA. While it will be used by a diverse array of clinical and non-clinical staff, the CMP will be of particular value to CHWs, who are another prominent component of many of the WPC-LA programs. The CHWs will use the CMP to support outreach, engagement and coordination activities – work that is challenging and too often not available to WPC-LA's vulnerable and hard to engage target populations.

Another important component of all of the WPC-LA programs will be to link individuals who are homeless to housing. There are a variety of housing solutions for people who are homeless. WPC-LA service providers will assess each client's needs and help them find the most appropriate option. These options range from family reunification, to rapid rehousing, and permanent supportive housing. WPC-LA will not pay for rental subsidies but it will provide the wraparound services needed for homeless clients to access various housing and subsidy programs and to achieve housing stability. DHS is partnering closely with LAHSA, HACLA, HACoLA, the City of Los Angeles, and other County Departments (DMH, Probation, Sheriff, Chief Executive Office, etc.) to match housing subsidies to WPC-LA clients. A key WPC-LA goal is to align the health care program expenditures provided through CMS and WPC-LA with the Housing and Urban Development (HUD) federal housing voucher program that is carried out locally through HACLA and HACoLA. Although WPC-LA enrollees cannot be guaranteed a federal housing voucher as a benefit of participation, we will emphasize the support of WPC-LA staff to sign up and obtain a housing voucher (e.g., Section 8). The use of physical plant infrastructure (e.g., sobering centers) is relatively small across programs and represents only a small share (<20%) of any program's budget.

Below we describe each WPC-LA program and how and why the WPC Toolkit will help improve health and reduce costs for each target population.

### Target Population 1: Homeless High-Risk

Clients who are homeless who are served under WPC-LA will be provided with a comprehensive and integrated set of services designed to improve health care outcomes, reduce utilization of high-cost public services including emergency medical and psychiatric services, and provide housing stability. A menu of interventions and services will be provided that are specifically tailored to the needs of homeless clients. These include:

- Homeless Care Support Services
- Benefits Advocacy
- Recuperative Care
- Sobering Centers
- Tenancy Support Services

Depending on the individual need of each client they may participate in all of the interventions or only a subset. Services begin with initial client outreach and engagement on the streets, in shelters, and in health care and social service settings and continue all the way through to permanent housing.

Outreach and engagement activities are necessary to engage the highest-risk homeless individuals. WPC-LA will expand street-based engagement activities through expansion of our Street Outreach Teams. We will roll out multidisciplinary, integrated street-based engagement teams during program years 2 and 3. Street Teams will each cover a set geographic area in urban and rural settings across Los Angeles County, and will: 1) build trust and rapport through regular contact, 2) help address immediate needs, 3) link them to housing, primary care, mental health, substance use disorder, and other supportive services, and 4) assist in navigating systems of care and to provide care coordination, including enrollment in other WPC programs.

The following is a description of the interventions to be implemented for the homeless high-risk target population. All proposed WPC-LA services described below are not otherwise covered or directly reimbursable by Medi-Cal. Some of the services provided to this target population are existing and through WPC-LA are being augmented and/or being brought to scale to be more proportional to the need among the target population in a county as large as Los Angeles.

Homeless High-Risk Intervention 1: Homeless Care Support Services

Homeless Care Support Services (HCSS) are comprehensive wrap around services provided to homeless clients to decrease their use of high cost health care services, improve health outcomes, and achieve housing stability. HCSS services will be provided to clients who are homeless who are high utilizers of public services and who have complex health and/or behavioral health conditions as described in Section 2.3. HCSS are provided in bridge housing and permanent housing. In fact, a key component of HCSS is linking every client to permanent housing and achieving long term housing stability.

HCSS includes outreach and engagement; ongoing monitoring and follow up; linkage to health, mental health, and substance use disorder services; non-SSI/SSDI benefits establishment (distinct from the services provided by the Benefits Advocacy program) assistance with life skills, job skills, and educational and vocational opportunities; crisis intervention; etc. HCSS providers provide a "whatever it takes" wraparound services to assist clients in regaining stability and improved health. Typically, a HCSS coordinator, who is equivalent to a social worker or medical case worker, has a caseload of 20 to 40 clients. The HCSS coordinator works with the client from initial outreach and engagement which may occur on the street or in a shelter through housing navigation and permanent housing placement. The HCSS continues to work with the client after housing placement to support the client with maintaining stable housing and ensuring the client is accessing any needed services and resources to improve health outcomes and reduce utilization of acute care services. HCSS is a longitudinal program and clients are disenrolled when client risk is deemed low enough for discharge or when the client refuses or does not engage in services. WPC-LA will drive a significant expansion in HCSS. We will leverage our Training Institute to promote reliable replication of these services and continue to develop skills of our HCSS workforce, including enhanced ability to perform medication review and support care transitions and use motivational interviewing and trauma informed care principles.

There are three HCSS tiers – bridge, high acuity, and low acuity. The highest level of services are provided in bridge housing settings. Clients in bridge housing have just come off of the streets, are least connected to services and supports, and are most likely to have health and behavioral health conditions that are not being managed. HCSS in bridge housing is provided 24/7. The remaining two HCSS tiers are provided in permanent housing and are called high acuity HCSS and low acuity HCSS. Clients in their first 12 months of housing receive high acuity HCSS services. The HCSS coordinator to case management ratio for high acuity HCSS is typically 1 to 20. This is a period of time when clients typically need a very high level of support with obtaining identification, birth certificates, and other documents; housing navigation and identification; completion of lease and rental subsidy agreements; scheduling and making appointments; coordinating transportation; forming relationships with health and behavioral health providers; learning to manage their health conditions; learning to manage bank accounts, grocery shop, prepare meals, maintain a household, etc. It is typical for HCSS coordinators to have multiple in-person and telephonic contacts with clients each week during their first year of housing and to provide a very high level of support services. Clients are evaluated for appropriateness to transition to low acuity HCSS when they have been in stable housing for 12 months, when they are having less frequent contact

with their HCSS coordinator, and when they are not accessing acute health and behavioral health services. The HCSS coordinator to case management ratio for low acuity HCSS will be 1 to 40.

All clients receiving HCSS are linked to permanent housing opportunities including a full range of community-based housing options such as non-profit owned supportive housing, affordable housing, and private market housing. Through partnerships with local Public Housing Authorities such as the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA), clients receive federal rental subsidies such as Section 8 tenant based or project based vouchers or a local rental subsidy through the DHS Flexible Housing Subsidy Pool which is described in more detail below. All WPC-LA clients who are linked to rental subsidies and permanent housing will be supported by a HCSS coordinator. In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities.

Cost studies in six different states and cities found that supportive housing (housing with supportive services such as HCSS) results in tenants' decreased use of hospitals, emergency rooms, jails and prisons. These studies indicate that health care systems see the most savings. In New York, reduced psychiatric hospitalizations resulted in an annual savings of $8,260 per person. In Denver and Los Angeles, annual reductions in physical health hospitalization saved $3,423 and $13,392 per person, respectively. A study of supportive housing in San Francisco found that placement into supportive housing significantly reduced the total number of emergency department visits by 57% and the total number of inpatient admissions decreased by 45% (Corporation for Supportive Housing).

Homeless High-Risk Intervention 2: Benefits Advocacy

The Countywide Benefits Advocacy Program will provide individuals who are homeless or at risk of homelessness who need screening or are potentially eligible for Social Security Income (SSI) or Social Security Disability Insurance (SSDI) with comprehensive benefits advocacy services. Benefits Advocacy Program is one of the tools to assist individuals with moving from homelessness to independent living. The Countywide Benefits Advocacy Program will include outreach to clients who are homeless who are potentially eligible for SSI/SSDI benefits; screening and assessment to ensure clients meet medical and non-medical requirements for SSI/SSDI; coordination of health and mental health records to support the SSI/SSDI application; assistance with obtaining additional health and mental health documentation as needed; legal consultation for complex claims, appeals, and hearings; internal quality assurance reviews; acting as a liaison with the Social Security Administration and State of California Department of Social Services Disability Determination Services; reconsideration filing for denied applications; coordination with health, behavioral health, and Homeless Care Support Services providers who serve the client. Benefits Advocacy specialists will work with a case load of up to 100 clients serve clients until SSI/SSDI benefits are established or the appeals process is complete. Comprehensive SSI/SSDI advocacy services will not be provided by any other WPC program. Through this intervention, the approval rate for initial applications is expected to be 80% or greater.

Obtaining benefits for which a client is eligible is a key step to obtaining income and housing stability. Many clients who are homeless and who have complex health and behavioral health conditions are not able to navigate governmental systems to establish their benefits. They need assistance with obtaining identification and birth certificates that are necessary to even begin the eligibility determination process

and a high level of support and coordination with health, mental health, and substance use disorder providers to obtain the comprehensive and appropriate clinical documentation and records to support a thorough and complete disability application. With SSI, clients are in a much better position to be able to contribute to meeting their basic needs such as food and shelter and many are able to leverage their SSI income to obtain permanent housing through affordable housing programs, shared housing, etc.

Homeless High-Risk Intervention 3: Recuperative Care

Recuperative care centers provide short-term residential care for individuals who are homeless and who are recovering from an acute illness or injury and whose condition would be exacerbated by living on the streets, in a shelter, or other unsuitable places (see Table 2.3b for detailed eligibility criteria). Recuperative care centers serve homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Recuperative care is an important component of the transition to permanent supportive housing for individuals with complex health and behavioral health conditions who need to recover in a stable environment where they can access medical care and other supportive services. Recuperative care services provide hospitals with discharge options for homeless clients which can reduce the length of hospital stays and result in decreased emergency room visits and hospital readmissions. A Chicago study looking at the impact of recuperative care on future hospitalizations found that patients who accessed medical respite care required fewer hospital stays (3.7 vs. 8.3 days) in the 12-months after program participation than those discharged from the hospital to the street or shelter. Another study out of Boston found similar results with homeless patients requiring 50% fewer hospital readmissions in the 90-days following medical respite program participation than those released to their own care (the street or shelter). Recuperative care is listed as a strategy in the federal plan to prevent and end homelessness.

DHS recuperative care center services will include 24/7 health monitoring (general oversight of medical condition, monitoring of vital signs, wound care, medication monitoring, etc.); assistance with activities of daily living (bathing, dressing, grooming, wheel chair transfers, etc.), but only when the activities are not covered through the In-Home Supportive Services benefit (e.g. IHSS); development and monitoring of a comprehensive homeless care support services plan; linkage to health, mental health, and substance use disorder services; non-SSI/SSDI benefits establishment; groups and social activities; transportation; facility operations; and coordination with permanent housing providers to support the transition of clients to permanent housing. Clients will stay up to 3 months in a recuperative care bed and will be disenrolled when discharged from the recuperative care facility or when a 3 month maximum is reached.

When patients on the psychiatric inpatient ward are discharged to an IMD or IMD step-down bed, hospitals are able to receive payment for the admin days the patient already accrued during their acute inpatient stay. Discharging patients to a clinically-appropriate alternate site means that hospitals cannot receive payment for those admin days and results in substantial loss of revenue, thereby incentivizing hospitals to keep patients as inpatients until scarce IMD or ERS beds become available. This pattern contributes to overcrowded inpatient wards and Psychiatric Emergency Services as well as creating other problems for our continuum of care such as long law enforcement waiting periods and the opportunity for clinical decompensation in less-appropriate clinical settings. By creating another discharge location for some of the sickest Medicaid patients, the Psychiatric Recuperative Care program would decrease costly and sometimes unnecessary acute care utilization while also increasing capacity for higher-acuity patients.

The Whole Person Care Psychiatric Recuperative Care program aims to create an additional discharge location for patients admitted to hospitals that accept a large number of patients from County Psychiatric Emergency Services. This would include 3 LAC Hospitals and a small number (3-5) of private hospitals who accept a large percent of PES patients for admission onto their wards. The average length of stay (LOS) in Psychiatric Recuperative Care will be 3 months, similar to the medical recuperative care model. The patients will be then tracked to additional programs with housing at the time of MH-RC discharge (the homelessness focused programs under WPC, for example).

DHS Psychiatric Recuperative Care will include all of the standard services detailed in the Medical Recuperative Care listed above plus enhanced services including increased security and dedicated staff training in de-escalation tactics. Clients will stay up to 3 months in a Psychiatric Recuperative Care bed and will be disenrolled when discharged from the facility or when a 3 month maximum is reached.

Homeless High-Risk Intervention 4: Sobering Centers

Through WPC-LA, DHS, along with a number of other WPC-LA participating entities, will create community based sobering center sites that will provide an alternative destination for law enforcement and fire departments to send people whose primary presenting issue at the time of contact is severe intoxication. These sites will also be accessible to the multi-disciplinary street based engagement teams and other community providers who come in contact with Medi-Cal beneficiaries that meet WPC eligibility criteria (see Table 2.3b).

Chronic inebriates have a huge impact on the communities, first responders, and hospitals in their vicinity. For example, hundreds of chronic inebriates are transported by ambulance from Skid Row to the LAC+USC Medical Center emergency room (ER) each month. Once at the ER, the emergency medical technician (EMT) must wait in the ER until the patient is received by ER staff, often resulting in up to a six hour wait time for the EMT known as “wall time”. In nearly all of these cases, the patient is evaluated, determined to be intoxicated, provided fluid, and released. There is no meaningful intervention administered in the ER for the patient and there is great cost to the fire department and health care delivery system. In addition, the ambulance and EMT are taken out of circulation and are not available to respond to other emergencies in the community. This situation is replicated in many communities across the county who have a high concentration of people who are homeless.

The goal of the sobering centers will be to provide a safe place for chronic alcoholics to sober up and to be linked to interventions that help them break out of the destructive cycle through streets, jails, and hospitals. The length of stay will vary but will be less than 23 hours. If longer duration services are required, alternative sites for services will be provided to the WPC-LA enrollee. Onsite services will include medical triage, point of care lab testing, client beds, oral rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, homeless care support services, substance use counseling, and linkage to health and behavioral health services. DHS will work closely with DMH and the DPH Substance Abuse Treatment and Control program to ensure that clients served by sobering centers will have access to a full spectrum of follow-up care including mental health outpatient and urgent care services and substance use disorder outpatient, detox, and residential services. Sobering centers will seek to link all clients to longer term treatment and housing options. WPC-LA participating entities will work with law enforcement and the local merchant community near a potential sobering center location so that the center is maximally used and benefits the WPC-LA enrollees as well as the overall community.

Homeless High-Risk Intervention 5: Tenancy Support Services

In 2014 DHS launched the Flexible Housing Subsidy Pool (FHSP). The FHSP is a supportive housing rental subsidy program designed to secure quality affordable housing for individuals who are homeless and who have complex health and/or behavioral health conditions. DHS contracts with Brilliant Corners to operate the FHSP. The FHSP consists of three components: 1) tenancy support services including housing location and retention services, 2) move in assistance, and 3) rental subsidies. Through WPC-LA, DHS is seeking to increase the number of clients who receive tenancy support services and move in assistance.

As part of tenancy support services, the FHSP will provide housing location services to assist clients with identifying safe and affordable housing. This service is an important programmatic resource due to the very tight housing market in LAC. Housing location services are especially important for participants who need special accommodations like wheel chair accessibility. In addition, the FHSP will also provide housing retention services which include crisis intervention, health and safety visits, unit habitability inspections, and coordination between the landlord and the case management provider to address any unit or tenancy issues. Housing retention services help ensure tenants transition from homelessness to housing and support long term housing stability. Tenancy support services staff follow clients longitudinally and disenroll them if the client leaves housing provided through Housing for Health programs, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in service.

The FHSP move-in assistance will provide clients with security deposits, furniture, household goods, and minor unit modifications to accommodate clients with mobility challenges and disabilities. This funding is necessary as these costs are a barrier to move in for most homeless individuals. Furniture and household goods support a smooth transition to the new home and the client's long term housing stability.

Although rental subsidies are not funded through WPC-LA, all WPC-LA programs will link homeless clients to rental subsidies and permanent housing. In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities. DHS has established partnerships with the Los Angeles Homeless Services Authority, the Housing Authority of the County of Los Angeles, and the Housing Authority of the City of Los Angeles to match federal rental subsidies with clients receiving WPC-LA services. In addition, WPC-LA clients will also be able to access the FHSP for a rental subsidy when a federal subsidy is not available. The combination of a rental subsidy and supportive services such as those provided through HCSS have been demonstrated to increase housing stability, decrease utilization of high cost public systems, and improve health outcomes for the most vulnerable high cost homeless individuals in many communities across the country.

Service teams /provider network: DHS will contract with community-based homeless services providers countywide who are experienced with providing health and/or behavioral health services for service-based interventions. All tenancy support services and move in assistance are proposed to be provided by Brilliant Corners through a contract with DHS. For interventions involving physical infrastructure (recuperative care, sobering centers), DHS will work with organizations that are accustomed to

operating 24/7 facilities in multiple locations in LAC. In addition to community based locations, benefits assistance services will also be provided with Department of Public Social Services offices and County custody facilities.

Prior experience/expertise: DHS has extensive experience providing high quality and successful housing and supportive service programs for people who are homeless and who have complex health and/or behavior health conditions. In 2009 DHS launched its first permanent supportive housing program, Access to Housing for Health, and also the Benefits Entitlement Services Team (BEST) program, which addressed barriers for homeless disabled adults by providing coordinated medical exams, mental health advocacy and case management assistance to homeless adults applying for SSI/SSDI. The projects demonstrated positive outcomes as defined by ED utilization rates, inpatient admissions, and benefits enrollment rates. DHS also implemented the first recuperative care program in Los Angeles County in partnership with a Federal Qualified Health Center to provide a short term residential setting with onsite health care oversight and support services that provide a safe and holistic environment for homeless people to rest and recuperative when they were discharged from a hospital. The recuperative care program led to reduced hospital lengths of stay, emergency room visits, and readmissions and improved health outcomes.

In 2014 DHS established Housing for Health as a division dedicated to developing and managing programs and services for people who are homeless. The goals of Housing for Health are to create 10,000 units of housing, end homelessness in Los Angeles County, reduce inappropriate use of expensive health care resources, and improve health outcomes for vulnerable populations. Housing for Health began by establishing an extensive network of partnerships with private and non-profit housing developers and providers, local Housing Authorities who administer federal rental subsidy programs, and homeless services providers who provide supportive services to homeless vulnerable clients. DHS has a Supportive Housing Services Master Agreement vendor list with over 50 community based agencies who are prequalified to partner on supportive housing programs. DHS has executed over 30 agreements with these agencies to develop and operate supportive housing programs countywide.

A key partnership has been the collaboration with Brilliant Corners to operate the Flexible Housing Subsidy Pool (FHSP). The goal of the FHSP is to secure decent, safe, and affordable housing for individuals who are homeless and who have complex physical and behavioral health conditions. The FHSP provides tenancy support such as housing location, landlord relations, and housing retention services; move in assistance including furniture, household goods, and security deposits; and rental subsidies.

Close collaboration with local Housing Authorities continues to play a key role in securing housing opportunities for homeless clients. Housing for Health works particularly closely with HACLA and HACoLA to match eligible clients to federal rental subsidies. Housing for Health is currently partnering with the Department of Mental Health, HACLA, and the Los Angeles Homeless Services Authority on the Continuum of Care (CoC) Bonus Project which is providing 547 CoC Bonus rental subsidies and support services to the most vulnerable homeless clients in the County. To date Housing for Health has assisted over 1,600 people into permanent supportive housing and has achieved very high housing stability rates with over 90% of clients remaining stable in housing after 12 months.

Plan-Do-Study-Act Approach: Each of the five interventions for the homeless high-risk target population described above will institute a Plan-Do-Study-Act (PDSA) approach to providing services including

identifying a goal, defining metrics, and developing a plan; service implementation; monitoring outcomes, successes, and areas for improvement; and integrating the lessons learned to continuously improve services and outcomes. Throughout every year of WPC-LA, service providers will seek to continuously improve services with the goal of achieving the best possible client outcomes. Interventions that lead to operational or outcome improvements will be shared broadly and contribute to the national conversation around improving housing permanency for this high risk population.

Integration and Care Coordination: Integration and care coordination are central to all WPC-LA programs including those services specifically targeting homeless clients. All clients will be assessed for need for any and all WPC-LA service components. Each of the WPC-LA homeless services includes a specific assessment of each client's needs and active coordination and follow up to achieve those needs. At every step along the way the client has an assigned coordinator who will assess their needs for housing, benefits, health and behavioral health services, etc., and will be responsible for directly providing those services or actively coordinating those services. At no time will the client be provided with an oral or written referral and be left to navigate access to services. The coordinator will provide the services directly or coordinate with a partner service provider to directly link the client to services including a warm hand off, introducing the client personally to other service providers, and following up with the client and service provider to ensure that the linkage is successful and the client is accessing services. The coordinator will follow up with all clients who do not successfully access needed services with the goal of addressing any challenges and completing a successful linkage. All clients will be tracked in the CMP which will support documentation of actual WPC-LA services provided and assessment and linkage to all WPC-LA services that will support the client with improved health and behavioral health outcomes and decreased utilization of acute care services.

## Target Population 2: Justice-involved High Risk

Re-entry

We will identify high-risk individuals leaving the jail when possible, engage them immediately after release and provide care coordination quickly upon re-entry into the community. Jail health staff may assess inmates and refer to WPC-LA reentry enrollment teams. Assessments and referrals will lead to the following set of activities:

- Assessment and Transition planning
- Integrated medical and behavioral health discharge planning services
- Communication with community service providers (e.g. primary care and behavioral health providers)
- Maintenance of medication regimens provided prior to release
- Benefits reinstatement – e.g. Medi-Cal, non-SSI/SDI benefits
- Assessment for housing needs and connections to housing resources, as necessary
- Development of community linkages
- Warm handoffs to various community providers deemed appropriate to serve an individual client.

At the time of release, the individual will be connected to the WPC-LA re-entry team for creation of the transition/discharge plan and navigation to their primary care medical home and other community-

based health and social service providers. We will ensure seamless integration of delivery to address the individual's medical, mental health, substance use, housing and other social support needs through a warm hand-off to the WPC-LA Re-entry team and from this team to other necessary community providers. In the first month of enrollment in the WPC-LA re-entry project enrollees will benefit from a set of high-touch, enhanced, care coordination activities aimed at successful engagement, swift creation of a comprehensive reentry plan and significant navigation support.

Enhanced care coordination activities will be carried out by medical case workers (MCW), community health workers (CHW), and social workers (SW), who will take full responsibility for coordinating care management and re-entry planning activities and will engage individuals at release or days following release. At the initial visit, a member of the WPC-LA re-entry care coordination team, most likely the CHW, will meet with the potential participant and perform a comprehensive assessment of medical, mental health and substance use issues, family/social support, benefits eligibility, housing stability and transportation needs in order to develop a care plan to support successful re-entry. The enhanced care coordination team will work with an extended array of interdisciplinary health and social service professionals, including registered nurses (RNs), social workers (SWs), medical case workers (MCWs), housing specialists, SSI advocates, community health workers (CHWs) and custody assistants (CAs), based on the particular needs of each client, in order to ensure adequate supports will be in place soon after release. Members of this enhanced care management team will support each participant by:

- Conducting the physical, psychiatric, and substance use exams/assessments.
- Helping establish benefits, including Medicaid or available cash assistance programs.
- Re-connecting with pre-incarceration primary care of other provider, if agreeable to the client, in a way that preserves continuity of care and the patient-provider longitudinal relationship.
- Supporting each enrollee to access a 30-day supply of medications for chronic or acute diseases.
- Transferring in-custody medical records to the client's community-based provider(s).
- Communicating with the community-based provider(s).

Whenever possible prior to release, for those referred while they are still in custody, a telemedicine visit or a face-to-face in-reach visit with the WPC-LA re-entry team CHW will occur. The overall goal of this "warm hand-off" is to support development of a trusting relationship with the community-based WPC-LA re-entry CHW so they can effectively navigate them to resources after release.

When possible, jail health services will provide a "coordinated release" to inmates who enroll in the WPC-LA re-entry program. A coordinated release involves a direct release of an individual to a community-based service provider, which in most cases is for residential substance use disorder treatment or for a mental health or medical condition. In a coordinated release, an inmate is released at a designated time with a warm handoff to a community-based service provider, who is waiting to transport and link the individual to needed residential or treatment services. A custody assistant (CA) is responsible for coordinating with the community-based program and making sure the client has necessary medication before being released. The CA escorts the client to the release area and walks the inmate outside of security to meet with program personnel. The Sheriff's Department has piloted the coordinated release program over the past year and has had great success with it. WPC-LA funding will allow expansion of this invaluable program as a vital part of ensuring potential program enrollees make contact with WPC-LA re-entry program staff.

The aforementioned enhanced care coordination activities will be the foundation to the initiative's efforts and the overall success of the WPC-LA Re-entry initiative.

The WPC-LA Re-entry program will be based at the jails and also at all eight WPC-LA RCCs located across the County. As mentioned earlier, re-entry teams will consist of SWs, MCWs, CHWs, and a licensed clinical social work supervisor that will oversee the program at each RCC. These teams will utilize CHWs who have a past history of incarceration. This shared experience with the target population is an important cornerstone of the proposed model and sets the stage for successful and trusting interactions with the client as early as possible. The average participant will remain enrolled for three months and disenrolled upon handoff to a longitudinal community-based provider or when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services. This is based on experience of our leadership staff in running similar, albeit smaller, programs where there is a wide range of length of enrollment in other re-entry programs. WPC-LA will use a PDSA process to establish the criteria that will guide for how long each individual client is followed, taking into account program enrollment and available resources.

CHWs will work under the supervision and with the support of SWs to accompany and navigate the client through the community-based health and social support system. Their activities will include the following services:

- Provide peer mentorship in the re-entry process and positive social support to reduce associations with prior associates that have been demonstrated to increase recidivism rates
- Attend medical, mental health, and addictions counseling and medication-assisted therapy visits, when appropriate, working closely with primary care and behavioral health teams to ensure that the client's issues are addressed
- Provide transportation from jail to their post-release home and to and from medical visits
- Make home visits and perform medication reviews
- Provide health coaching, chronic disease self-management support and harm reduction
- Maintain contact with the youth and family post-release to ensure proper social supports are in place to best transition the youth back into the community with family or into the child welfare system
- Support medication adherence
- Set and track health care goals around smoking, exercise and diet
- Ensure that appropriate connections to support and enabling services occurs adequately to maintain the client in the community
- Assist with establishment and maintenance of non-SSI/SSDI benefits to which the client is eligible
- Work closely with housing specialists (e.g. move-in readiness and assistance) and legal assistants, as necessary
- Support criminal justice navigation, such as assistance in making scheduled court appearances, parole, and/or probation appointments
- Assist with connections to legal aid for issues such as child support and restitution.
- Assist with coordination of other activities as needed to support re-integration with the client's families and communities (e.g. tattoo removal, family counseling, parenting education, education and vocational training) in partnership with WPC-LA regional partners and community-based organizations
- Navigating to community-based re-entry organizations (e.g., Los Angeles Regional Re-entry Partnership entities) to address additional social determinants of health such as education, employment, food security, and family reunification.

The use of a previously incarcerated CHW who successfully reentered the community will help the client navigate care, keep them connected to critical services, and overcome challenges when they arise. Hiring CHWs who have also been impacted by the criminal justice system has been proven to enhance patient engagement in primary care services. Patients returning from incarceration often cite experiences of discrimination in the community healthcare setting due to their history of incarceration. Because of this and negative experiences in the correctional health setting, they mistrust and avoid using the community health system. CHWs with a history of incarceration can build trust with patients and act as cultural interpreters to enhance engagement and ensure patients' needs are met. In addition to the CHW connection, by connecting patients returning to the community with a primary care medical home and/or a behavioral health home, and supporting their transition to the community during a high risk time, we expect to reduce ED and ambulatory care-sensitive hospitalizations and help break the cycle of repeat incarceration. The provision of an adequate number and supply of medications at release will also help reduce the likelihood of the immediate need to access avoidable urgent and emergent health care services.

For male participants, there is a Community Re-entry and Resource Center (CRRC) that is available just outside the release area at the Twin Towers Correctional Facility in downtown LA, where all males are released into the community. As male inmates are released, they can stop at windows staffed by the Department of Mental Health, Probation Department, Department of Public Social Services, Sheriff's Department Community Transitions Unit, and community-based organizations to obtain assistance and linkage to benefits and community services. CRRC staff will identify WPC-LA participants that access the CRRC and will assist with connecting them to the WPC-LA Re-entry teams and providing any needed bridge resources and assistance. This will be particularly helpful in connecting individuals who are released unexpectedly from court or after just a few days or hours in jail.

Female participants are released from the Century Regional Detention Facility (CRDF) in Lynwood, where there is currently not an equivalent re-entry center. As part of WPC-LA, a satellite CRRC will be established in the release area at CRDF, with services available 7 days per week, 10 hours per day. Space has been identified which will be renovated for this purpose, adjacent to the window where inmates receive their release funds. Staffing and services will include:

- Department of Mental Health medical case workers, to provide connection to community-based mental health services and ensure medication continuity
- A Deputy Probation Officer to provide transitional services, conditions of release, transportation to treatment for inmates being released to probation supervision
- Sheriff's Department custody assistants, to take benefits applications or confirm the status of submitted applications, coordinate inmate contacts with case managers, liaison with jail personnel, and coordinate transportation
- WPC-LA Housing liaisons and case managers, to provide connections to bridge housing and case management for homeless and unstably housed individuals

As at the men's center, the women's CRRC will identify potential WPC-LA participants and will assist in connecting them to the WPC-LA Re-entry teams.

Community Referral Program and Extended Care

Some high-risk individuals may not be picked up while in jail, including many with short jail stays, those in the AB-109 probation populations, and those returning home from California Department of corrections facilities. These individuals may return to the community without a pre-release care plan or community-based supports. When identified in the community, the WPC-LA Community Re-entry program will engage them, assess their needs, develop a care plan, and help coordinate care and navigate them to community based resources. WPC-LA teams will perform all of the community re-entry support activities listed above; however, we anticipate that the initial 3 months of this engagement will be much more complex and intense – requiring additional time and support from our care team.

At the end of the 3-month initial engagement (on average), the WPC-LA team will find that a subset of individuals (perhaps 25-35%) in the Adult Jail Referral and Community Referral Programs require ongoing care management support to ensure successful re-integration into society, and avoid recidivism and other undesirable outcomes. In the Adult Extended Care program, 25% of the individuals in Adult Jail Referral and Community referral programs will require ongoing care management. The Adult Extended care program will allow WPC-LA teams, to follow this higher risk subset of individuals for an additional 6 months, continuing many of the activities delineated previously.

Juvenile Aftercare

The handoff of WPC-LA Juvenile Re-entry clients from within the LA County Juvenile Detention Facilities (Central Juvenile Hall, Barry J. Nidorf Juvenile Hall, Los Padrinos Juvenile Hall, Challenger, and other Camps) to the Aftercare Planning teams will work similarly to the models described above for adults. Juvenile Detention Teams will identify candidates for the Youth Aftercare program in the Juvenile Detention Facilities through the completion of a Multi-Disciplinary Assessment (MDA), which is designed to identify the most appropriate camp placement and the most suitable services for the youth while in Camp following release. Because the ultimate placement of the youths is unknown at the time of detainment and pending the results of the petition process, the beneficiaries may be discharged from Juvenile Hall or placed into Camp to be discharged at a later date. We will identify and follow high-risk youth that meet WPC Juvenile Justice Program criteria, such as those who have comorbid mental illness, SUD and/or medical conditions, from detainment to when they leave the facilities. At the point of release, the Aftercare team will receive a re-entering justice involved youth who meets WPC criteria, and work with them to implement the previously established post-release care plan, including ensuring the youth's receipt of appropriate supports and services upon their return to the community. The Aftercare CHW will serve as the central point of contact and bridge between the community and youth, monitor service delivery and progress achieved by youth and their parent(s)/caregiver(s), and provide referrals and linkage to appropriate physical and mental health programs.

Service teams /provider network: Information on the service teams used in each intervention is provided in the text above.

Prior experience/expertise: LAC and its partners have robust experience in working with the health-related issues of justice-involved populations. The interventions here build upon existing DHS programs, including non-SSI/SSDI benefits establishment and advocacy programs, and housing navigation programs, including connections to permanent supportive housing and care support services through partners (WPC Participating entities). As a testament to their knowledge, the partners for the re-entry project were accepted to be a part of a national learning collaborative funded by the Department of

Justice's Bureau of Justice Assistance and led by the Urban Institute and Manatt, LLP. The learning collaborative, entitled the Connecting Criminal Justice to Health Care Initiative, is taking place this year and will allow for LAC and its partners to be well prepared for the successful implementation of the re-entry program under WPC-LA. The support of expert consultants and national experts about re-entry and health care for justice-involved populations should add valuable guidance to our WPC efforts.

Plan-Do-Study-Act approach: WPC-LA Re-entry teams will stay in regular communication with jail and Juvenile Detention facility health staff through meetings at which they will discuss complex clients and handoffs. Meeting participants will include all available staff, including community health workers, supervising staff (e.g. SWs and jail-based RNs), and program leadership. These teams will engage in Plan-Do-Study-Act processes to review and improve care coordination processes. The senior program lead, with support from the WPC-LA performance improvement team, will lead these discussions and follow up on progress.

Integration and care coordination: Jail health staff and those at Juvenile Halls and Camps will with coordinate, when possible, with WPC-LA Re-entry teams for engagement and ongoing care. WPC-LA re-entry program staff will ensure participants have a sufficient supply of medications; schedule community based appointments with a primary care medical home and behavioral health providers; address transitional and/or permanent housing, job training, and family reunification services; and link to other services. The WPC-LA Re-entry team CHW will receive a warm handoff- from the jail-based coordination team, greet and enroll the client in WPC within 5 business days of release and accompany the individual to services and their follow up primary care visit. The WPC-LA Re-entry team CHW will work to support the patient for an average of three months. The CHW will help them navigate the system and address their complex needs in partnership with the client's primary care and behavioral health teams. As with all WPC-LA programs, the use of the WPC-LA CMP will be used in the re-entry programs and will help link all care and service recommendations in a single, viewable place so to support the implementation of a robust service plan in the community. We will train the jail-based care coordination teams to view the CMP and use as a tool to help identify participants in the WPC-LA re-entry program who may recidivate.

In addition to making the connection to the health home, the CHW, working with jail health staff, will expedite the confidential sharing of medical records and health information with community medical and behavioral health providers upon release. This might include clinical notes, study results and/or other important information needed for ongoing care. Initially, the administrative assistant will print copies of the medical record for the client to carry with them upon discharge. During Year 1, the WPC-LA leadership team will work with Jail Health Services to develop a clinical discharge summary within the electronic medical record system at the LAC jail. This summary will be printable, but with permission, will also be available through data integration platforms across the system, including in community primary care clinics to improve coordination of care. This will allow the re-entry efforts to be informed by the care provided within the jail since this jail-based care is not a part of the proposed WPC intervention.

In many areas, we will work closely with community partners on re-entry activities. Engaging numerous partners across all eight RCCs will require coordination strategies and work to ensure consistency of the intervention across LAC. We will leverage the WPC-LA Training Institute to promote reliable replication of re-entry services and to develop the skills of our workforce, including training on care planning, medication review and adherence support, chronic disease self-management support, care transitions

support, and the use motivational interviewing, harm reduction, and trauma informed care principles. We will also use monthly cross-RCC case conferences, mini-learning collaboratives, and quality improvement meetings to support this effort.

Additional Service: Mental Evaluation Teams

WPC will accelerate the implementation of Mental Evaluation Teams (MET) in Los Angeles County. The County MET Service aims to help de-escalate situations in the field when a mentally impaired client encounters law enforcement officials. The MET additional service, which consists of a Deputy Sheriff and a Psychiatric Social Worker, evaluates the client, performs crisis management, and when appropriate transports the client to a sobering center or a psychiatric urgent care facility in lieu of arrest. This intervention reduces justice system engagement of individuals that suffer from behavioral health issues at the point of arrest and "diverts" them to treatment facilities where they may receive services they need to be healthier and reduce unnecessary utilization of the healthcare and criminal justice system.

MET Teams, during years 2-3, will be funded through incentive payments, as detailed in the Incentive Payments section of the Budget Narrative.

## Target Population 3: Mental Health High-Risk

Mental Health High-Risk Intervention 1: Intensive Service Recipient (ISR)

The ISR program is designed to address the multiple and complex needs of clients that are high utilizers of psychiatric hospitals (see Table 2.3b for detailed eligibility criteria). The program will offer an array of non-billable Medi-Cal services to Medi-Cal beneficiaries, such as: outreach and engagement within institutions, crisis support services, service navigation, benefits establishment, linkage to housing resources (either directly or via the WPC-homelessness focused programs), transportation, assistance with emergency food, clothing, personal hygiene items, household goods, requests for legal documents and legal assistance, connecting to health care and, when appropriate, support with education and employment connections. These services will complement the Medi-Cal billable clinical and case management services ISRs will receive to assist them with their recovery.

The in-reach into psychiatric inpatient units included in the ISR model serves to promote rapport and ensure that a firm linkage to the ISR program occurs rapidly. Upon discharge from the hospital, the ISR program will ensure the discharge plans are implemented. The ISR team will provide up to 60 days of intensive services post-hospitalization. Services will focus on integrating evidence based practices (EBPs) around trauma informed care such as trauma focused cognitive behavioral therapy (CBT), Seeking Safety and Prolonged Exposure interventions. The use of these EBPs with clients who suffer from SMI has been shown to support recovery and the management of specific trauma. After 60 days, there will be a warm handoff to an MHSA full service partnership, to DMH's Integrated Mobile Health Team or to a community-based organization such as Special Services for Groups (SSG) or HealthRight 360. Clients may also be disenrolled when they refuse or do not engage in services.

Each ISR team will have a psychiatric social worker who will serve as hospital liaison and work closely with the county and FFS hospitals within their SPAs to ensure seamless discharge planning and aftercare. Once the client is receiving care from the ISR program, the ISR case manager, who is a social worker, will

be responsible for assuring that all care is coordinated across areas of need. He or she will communicate with community-based agencies as needed, and will serve as the central point of contact for managing the client's overall care. The clinical supervisor on each team will be responsible for coordinating the activities of the team, maintaining collaborations between the partner departments, and developing, training, and updating policies and procedures that support ISR care coordination and team operations.

The beneficiary will meet with a psychiatric social worker while still in the psychiatric hospital and learn about the ISR program services. The psychiatric hospital will share the client's basic health information with the ISR program to facilitate continuity of care. The ISR community health worker will visit the beneficiary in the home or in the community to link him or her with necessary services. The use of peers as community health workers to provide regular support for those with SMI, who suffer from cumulative trauma is an integral part of the ISR Intervention. The beneficiary will have contact with this same person for all of their needs so to provide continuity of care and to create a strong rapport. The ISR team will take a very hands-on role in assuring the client is linked with needed services, including arranging transportation if needed. Services provided by the ISR team will ensure that beneficiaries experience improved access to culturally competent services appropriate to the necessary level of care.

Mental Health High-Risk Intervention 2: Residential and Bridging Care (RBC)

To reduce institutional length of stay and facilitate successful community re-entry for individuals in inpatient psychiatric units, exiting IMDs, and being treated in ERSs, the RBC Transition Team will supplement existing discharge planning functions (except in the IMDs) and post-discharge services with the following currently Medicaid non-reimbursable services:

- Identify individuals already enrolled in intensive integrated services programs such as Full Service Partnership (FSP) programs or served by other outpatient service providers and act as a liaison between these providers and the inpatient unit, IMD or ERS teams for the purpose of coordinating treatment and discharge planning.
- Develop enriched after-care plans that cover a broader range of needs (e.g., shelter and food), than those typically prepared for persons in healthcare institutions.
- Facilitate linkage to community-based resources, including coordination with substance abuse programs, mental health clinics, residential providers, Full Service Partnerships, self-help groups, and bridging services. The program will ensure continuity of care and consumer support during the discharge process.
- Assist in benefit establishment activities to ensure applications for benefits are initiated in a timely manner. This will include advocacy and identification of system barriers that prevent the establishment of benefits.
- Provide peer support and support family involvement as a means of promoting community reintegration (e.g., the program will employ community health worker/peer bridgers, support client-run self-help groups)
- Identify and address other system barriers, including social and financial issues, to successful reintegration of individuals into their communities.

The RBC Transition Team will employ a recovery approach to treatment with a strength-based focus that empowers clients to develop their goals toward community reintegration, skills to become self-sufficient and the capacity to increase current levels of community functioning. By working directly with the

clients and ensuring that they are part of the process, the client will know what to expect and who to work with after discharge, thereby promoting a more seamless transition.

The RBC Transition Team will rely, in part, on the larger WPC-Housing Pool in Los Angeles County called the Flexible Housing Subsidy Pool (FHSP) and federal housing subsidies available through the County and various City Housing Authorities which work closely with Housing for Health. WPC participants within this portion of WPC-LA will be, when appropriate, referred to DHS Housing for Health for housing navigation and support services, move-in assistance as well as support with completing applications for federal or local housing subsidies. The RBC Transition Team will collaborate with representatives for Housing for Health to ensure that the special needs of these clients are addressed. The housing subsidies will be funded outside of WPC-LA in the portion of the housing pool focused on subsidizing room and board. WPC funds will be provided to support the navigation, stabilization and move-in-assistance portions of identifying and securing housing. Housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Additionally, for WPC participants moving from inpatient facilities or IMDs to enriched residential settings, some portion of support and stabilization services may be available through the housing pool to augment existing services so these often hard-to-serve clients have more enabling and support services to help them succeed in an unlocked, less restrictive, community-based setting.

The RBC Transition Team program will collaborate with County and private hospitals, Service Area Navigators, institutional providers, FSP programs, community peer support programs, mental health clinics, patient-centered medical homes delivering medical services, psychiatric emergency outreach teams, alcohol and drug programs, residential and other community providers to ensure access to and coordination of services that are specific to the individual's needs and support wellness and recovery. DMH has a long history of providing intensive case management to the mentally ill population and therefore has many existing resources and connections that will be available the RBC Transition Team to perform their work. The addition of dedicated staff who work directly with both the clients and external service providers will ensure that transitions are successful and that they occur earlier than they would otherwise. This will decrease inappropriate utilization of the acute psychiatric inpatient beds, IMD beds and ERS by clients who can more appropriately be treated at other levels of care.

We estimate that approximately 40% of patients in the RBC program will be identified in an IMD. Approximately 50% of the services provided for each enrollee will be provided within the institution they are enrolled from (i.e., inpatient psychiatry unit, IMD). The other 50% will be delivered in the community based, unlocked setting. For clients originating from the IMD, we will work closely with IMD case management teams to identify potential clients for the WPC-LA RBC program. WPC-LA RBC Teams will provide enhanced care coordination support during the weeks and months following discharge from the IMD. The enhanced care coordination support services begin prior to discharge when the IMD case management team arranges a “warm hand-off” to the WPC-LA RBC team post-discharge where formal WPC-LA RBC Transitions program enrollment will occur.

Service teams/provider network: The ISR program will identify patients in County and FFS private psychiatric hospitals. The ISR team will access community services within a client’s neighborhood. An intensive service model with small caseloads is a critical element of the ISR program to ensure that staff members have the capacity to provide needed comprehensive and intensive services. The ISR will be a

multi-disciplinary, interagency, field-based team, offering a range of therapeutic and case management interventions to stabilize the client. The team will also work collaboratively with family members and other natural supports from the community, such as faith-based organizations.

The RBC Transition Team will be composed of DMH employees who will coordinate their activities with DHS County hospitals, DPH, and DMH contracted IMD and ERS providers countywide. DMH will establish one team in each SPA, working out of the local RCC. There will be a total of eight teams. The staffing for each team is: (1.0 FTE) Clinical Supervisor; (2.0 FTE) Licensed Clinical Social Worker and (3.0 FTE) Community Workers.

Prior experience/expertise: DMH has decades of experience serving the SMI population including high utilizers of psychiatric hospitals, the homeless, veterans, those involved in the justice department and diverse cultural populations. DMH's experience includes conducting comprehensive assessments, intensive outreach services, clinical interventions (including numerous evidence-based practices), co-located services in the community, and field-based and in-home services. DMH will draw on their experience in planning, implementing, growing, and monitoring programs such as the Integrated Mental Health Team Full Service Partnership and other intensive integrated programs focused on providing integrated services along with housing services. The ISR program will ensure that each client receives mental health, physical health, and substance abuse screening, comprehensive assessments, and treatment planning informed by DMH's experience and expertise in integrated quality care.

DMH Countywide Resource Management (CRM) will oversee administration of the RBC Transition Team program. The CRM is an administrative DMH program that provides overall administrative, clinical, integrative, and fiscal management functions for the department's multiple services. CRM has a long history of interagency and interdepartmental collaboration with the Chief Executive Office, Board of Supervisors, DHS hospitals (County Hospital Adult Linkage Program and PES Relief Plan I, II, and III), DPH and federally qualified health centers (Project 50 Lead), DMH Assembly Bill (AB 109), various law enforcement agencies, the criminal justice system, Department of Public Social Services, Social Security Administration, and Office of the Public Guardian. In addition, CRM had undertaken the responsibility for the development of urgent care centers and enriched residential services programs under the Mental Health Services Act (MHSA), along with responsibility for DMH IMD Administration. The program is also responsible for implementation of new urgent care centers and crisis residential programs under Senate Bill 82 California Health Facilities Financing Authority. This prior and current experience will serve as a strong foundational support for this program.

DMH also has extensive experience deploying community health workers, including surveillance, community engagement, care management, and social support interventions.

Plan-Do-Study-Act approach: Throughout the implementation of the two interventions for the mental health high-risk target population, senior project leadership from DMH will work with the participating partners, including acute care hospitals, IMDs, and ERS to test and implement system and practice changes that support achievement of desired program outcomes using the PDSA process. A workgroup composed of supervisory staff from each intervention will meet at the inception of the project and on a quarterly basis thereafter, to test aspects of the new services being provided, and to review complete test results. Qualitative and quantitative data will be reviewed to determine whether program changes are necessary to improve results. Teams will share the results of their improvement efforts in regular reports to department leadership and county administration.

Integration and care coordination: The ISR program will provide enhanced service integration and coordination between behavioral health, physical health, and substance use disorder services, as well as with psychiatric hospitals, community-based services, and housing. ISR staff will use information from a variety of different sources so to piece together a comprehensive clinical story for each client so a tailored approach to helping stabilize the patient can be developed. The integration of clinical and social services information is key to the success of this program. The ISR team will operate under one set of administrative and operational policies and procedures to ensure integrated and coordinated services when more than one entity is involved. The intensive service model will lead to greater success in engaging and connecting individuals to medical, behavioral health, and social supports, improving access to appropriate levels of care, and quality of care, and reducing unnecessary costs incurred by excessive and/or avoidable emergency and inpatient service utilization.

Placement Support Initiative (PSI)

As a support to the Residential & Bridging Care program, WPC-LA Placement Support Initiative (PSI) initiative will augment funding to Adult Residential Facilities (ARF) to pay for uncovered personnel and services that allow participating ARFs to accept higher intensity WPC-LA seriously mentally ill clients, including those with co-occurring substance use disorders. Participating ARFs, with specialized staffing, will have capacity to care for more WPC clients creating additional placement options for high intensity clients that are awaiting release from Fee For Service (FFS) hospitals, the County's acute psychiatric hospitals or jails; or those that are chronically homeless. RBC staff will review referral packets from other WPC programs FFS and County hospitals, and authorize admission to the PSI initiative based on clinical appropriateness. Participating ARFs will hire peers and other paraprofessional staff to provide on-site augmented supervision (e.g. twenty-four hours per day, seven days per week), enhanced socialization activities, and client/family self-help and peer support, and other supportive services that are not Medi-Cal reimbursable and are not funded by the board and care portion of the ARF rate. These services will be supported by WPC-LA investments, and success in achieving WPC-LA goals will earn WPC-LA an incentive payment. WPC-LA will not requesting a service payment for the Participating ARFs separately from the other programs for the mental health high-risk population.

The RBC Transition Team will integrate care for each patient across a wide variety of clinical settings. Because patients will be coming out of institutions, there will be a need for the RBC team members to assimilate clinical information from long institutional stays and previous community based care. Reestablishing care in the community will be a priority and ensuring that the client's clinical services are convenient and accessible is also critical. RBC team members will be required to use the CMP and the community resource database available through WPC-LA to identify the appropriate services for each client and create a comprehensive and integrated care plan. The community health workers on each team will work with patients to ensure that they understand the various aspect of their care plan and have a clear sense of the short and long-term detail. Because many of the clients have been institutionalized for many months, if not years, the RBC team will be required to focus on all aspects of daily living required for the client to be successful in the community rather than a locked or structured environment.

Mental Health High-Risk Intervention 3: Kin to peer (KTP) Program

KTP clients are high utilizers of psychiatric emergency services and inpatient hospital systems. They typically lack the support of kin needed to help them stay connected to services across programs. These clients will benefit greatly from establishing an enduring relationship that provides them with the kin support needed to achieve personal recovery and pursue community reintegration.
Studies have shown that clients who receive peer support use inpatient services less, have more engagement with treatment providers and community, improve their social functioning, have a better quality of life and are more hopeful. With shared experience as a family-like bond, peers can be effective in building a trusting relationship that is key to maintaining the road to recovery and reintegration. With an enduring role, peers can also mitigate the trauma that clients experience in transitioning between programs that is often experienced despite best efforts to provide "warm handoffs". Further, the enduring relationship that is core to kin function will position peers as advocates who can improve the long-term adherence to care plans, increase the accountability of the network of care providers across the county, and decrease recidivism in and out of psychiatric inpatient units, the streets and jail.

Kin to peer is a Mental Health High-Risk Intervention that will be administered as a social support enhancement. KTP is a social support program that provides extended serves to a subset of clients who have no family involvement and/or minimal to no alternative social supports or a lack of healthy social support as they are discharged from the ISR or RBC programs. Clients with four or more psychiatric hospitalizations within a calendar year are initially eligible for the short term ISR program for up to three months; in planning the discharge from the ISR program, a subset of vulnerable ISR clients will be identified for enrollment in the KTP program. KTP enrollees may also be identified in planning for discharge from the RBC program. KTP clients will be enrolled for up to 12 months. An individual will not be simultaneously enrolled in KTP and in ISR or RBC at any time.

KTP will provide a longer term intensive peer model with a smaller staff to client ratio compared to the ISR program in order to provide frequent and more in depth contact with the consumer. The KTP peers will work intensely and frequently with the consumer in the same way a family member may to provide hope, social support, and to ensure the consumer's immediate and long term goals are being met. As a result of the intense support and frequent follow through with the client, the goal is to reduce the risk of unnecessary psychiatric hospitalizations.

The longer term specific services Kin-to-Peer will provide include the following through greater intensity and frequency of services for up to 12 months:

1. Daily contact and at least one face to face weekly visit
2. Assistance with activities of daily living (show client how to organize household, cook, wash clothes, etc.), when the activities are not covered through the In-Home Supportive Services benefit.)
3. Call daily to make sure medication is taken and check on how client is feeling and to identify triggers
4. Link to Peer Support/Self- help groups
5. Link to spirituality support
6. Accompany client to parks, museums, and other civic activities
7. Assist with arranging transportation, teach client how to use the public transportation system
8. Accompany client to market and or other shopping places
9. Make sure all necessary appointments are scheduled and accompany client to appointments
10. Take consumer out on a social outing to increase social skills

11. Provide companionship, watching TV with client, talk, listen and other activities to reduce isolation
12. Take walks with client to encourage exercising
13. Increase problem solving skills
14. Recognize and praise positive outcomes
15. Reconnect client with family and/or appropriate friends.
16. Assist with establishing an appropriate social support system for client

### Target Population 4: Substance Use Disorder (SUD) High-Risk

The SUD-ENS program will include supportive interventions and services designed to improve connections, remove barriers, and enhance completion of SUD treatment for high utilizing and high-risk Medi-Cal beneficiaries (see Table 2.3b for detailed eligibility criteria). As part of the SUD-ENS, individuals will receive the following intervention/services that are not currently reimbursable by Medi-Cal:

- Community health worker (CHW) face-to-face or telehealth engagement and enrollment for eligible individuals (opt-in)
- SUD Navigation and Treatment Support: CHW navigation services over a 2- to 3-month period until a DMC-ODS SUD treatment provider assumes care for the patient and begins to provide Medicaid billable services. CHWs will serve relatively small caseloads (~20-30 clients at a time). CHW activities include:
    - Assistance in making initial SUD intake appointment and follow up appointments
    - Motivational interviewing to engage beneficiaries in their SUD treatment
    - Addressing logistical or social barriers to SUD treatment (e.g., instruction on use of public transit to navigate to appointments or assistance with filling prescriptions)
    - Accompanying the beneficiary from the hospital to an SUD treatment facility
    - Supporting successful transition from withdrawal management services into community SUD residential or outpatient services, including Nurse Family Partnership for pregnant women
    - Scheduling intake appointments in drug courts, probation offices, or DCFS offices
    - Accompaniment to appointments or follow-up to ensure beneficiaries attend their intake and ongoing treatment appointments with SUD treatment providers
    - Enhanced Care Support Supplements that help beneficiaries remove barriers to accessing SUD treatments

SUD-ENS teams will engage high-utilizing and high-risk individuals with SUD to heighten their readiness and willingness to enter SUD treatment increasingly available through the newly adopted Drug Medi-Cal Waiver. Outreach, engagement, service navigation, transportation, and child care assistance provided by SUD-ENS team members will provide comprehensive support for beneficiaries seeking services in a variety of settings across the county. SUD-ENS teams will engage these individuals, initiate the assessment and efficiently navigate them to SUD services when they are most ready to receive it. Supporting these individuals to effectively access SUD treatment through Drug Medi-Cal will improve SUD access and adherence to treatment for this hard-to-engage population, and reduce avoidable acute care utilization that is frequently seen in individuals with untreated SUD. SUD-ENS teams will follow clients for an average of 2 months and clients will be disenrolled following handoff to longitudinal SUD

team is complete, when client risk is deemed low enough for discharge, or when the client refuses or does not engage in services.

Service teams /provider network: SAPC will operate this program directly with one programmatic staff lead, 4 senior clinical social workers, and 8 SPA-level teams of 3 CHWs each, stationed in WPC-partner agencies' offices or clinics. Contracted SUD service provider agencies will provide transportation for patients in residential levels of care and childcare assistance for patients in outpatient levels of care. The CHW teams will provide transportation assistance for patients in outpatient levels of SUD treatment. The service team members and their roles are shown in the table below.

Prior experience/expertise: Many of SAPC's contracted treatment providers and drug court and mental health service partners are very skilled in engaging individuals in services and treatment. A few contracted providers already use CHW-like models, hiring individuals with lived experience to assist beneficiaries with navigating services and maintaining motivation to participate in SUD treatment, but have not been able to scale the practice due to lack of reimbursement. DMH has also had success using SPA-level teams of CHW-like "navigators" with lived experience to assist individuals with SMI in initiating specialty mental health treatment.

Plan-Do-Study-Act approach: To measure and improve the effectiveness of CHW services, the supervising social workers will incorporate regular monitoring and reporting as a part of ongoing training for the CHWs (initially, quarterly, then monthly). The main process metrics for SUD-ENS will be successful initiation of SUD treatment following referral, adherence, and completion. The social workers will be responsible for observing and recording improvements in the techniques and work patterns of the community health workers using these and other metrics for their clients. The staff analyst will be responsible for observing and evaluating the PDSA processes and reports across the teams serving the different SPAs. For transportation and childcare, the staff analyst will track rates of SUD treatment initiation and adherence and identify quarterly trends by SPA, referral source, service provider, or other factors. The staff analyst will share this information with the Social Workers and CHWs to identify deficiencies and develop solutions to test in PDSA cycles.

Integration and care coordination: For high-utilizing and high-risk Medi-Cal beneficiaries with SUD, handoffs between acute or community settings and SUD treatment are critical moments when beneficiaries often fall through the cracks. Providing information about access phone lines or walk-in availability for SUD treatment is important, but high-need individuals are not likely to respond to information alone. Instead, a warm handoff guided by a trained CHW will improve transitions into SUD treatment. Using CHWs to establish and strengthen an individual's connection to treatment is an evidence-based practice from the LAC mental health system that can also be applied to SUD treatment.

Each CHW team and Social Worker will also collaborate with other WPC-LA teams in their SPA to share information, cross-refer, and coordinate care, using agreed-upon referral flows and processes. Handoff protocols between the SUD-ENS team and Drug Medi-Cal case management and care coordination services will be developed in tandem, with clear guidelines and processes to avoid duplication. CHWs will also receive a "report back" from contracted treatment providers to communicate referral outcomes at the individual and aggregate level.

CHW training will cover not only systems of care and processes for access to SUD treatment, but also for access to physical health, mental health, and social services, so that CHWs understand and can

coordinate with them when necessary. To avoid confusion and duplication, the training focus will be how and when to refer to different programs, how to communicate with them regarding the beneficiary's care plan, and how to complete a warm handoff.

### Target Population 5: Medically Complex: Transitions of Care (TOC)

The TOC program will offer comprehensive care management services aimed at providing seamless transitions for patients from hospitals to their community environments with the goal of improving health outcomes and preventing avoidable re-admissions. The program will offer a four-week intervention beginning while the patient is still in the hospital. Each patient will be paired with a CHW and a support team consisting of a clinical social worker (SW) and a medical case worker (MCW). The CHW will visit the patient in the hospital and perform a comprehensive assessment of his or her needs. The CHW will review the reasons for the repeated admission, assess the patient's needs, and develop a care plan that addresses them in order to prevent future readmissions. Prior to discharge, the TOC team will create a transitions-of-care discharge plan that will provide an overview of needed services after discharge. The CHW will review potential medications and red flags that should warrant contact with his or her primary care provider, ensure that the patient has a plan to fill any needed prescriptions, ensure that all discharge instructions are communicated to the patient in a culturally competent manner, provide help scheduling follow-up appointments to primary care and specialty providers, and arrange transportation as necessary. The CHW will ensure that the inpatient and primary care teams are aware of patients' needs prior to discharge. The CHW will also assess social needs, including housing needs, and work with the local RCC housing supports and WPC-LA homeless high-risk program staff to connect patients to housing and housing services. This includes the placement support funding that is part of the partner downstream incentive arrangements created as part of WPC-LA.

Following discharge, the TOC team will ensure linkages between the hospital, primary care, home health, and social services and the CHW will support the client in following through with the recommendations in the TOC discharge plan. The CHW, working with support from the supervising SW and MCW, will:

- Conduct a "home visit" within 72 hours of discharge to:
    - Ensure the patient is taking new medications and has set aside old medications.
    - Help the patient schedule follow-up appointments if necessary and develop strategies to increase attendance (i.e., arrange for transportation).
    - Address home health needs with support from home health agencies.
    - Address social service needs through referrals and linkages to social service organizations.
- Accompany the patient to their follow-up primary care visit to:
    - Ensure that the hospital discharge summary is transmitted to the primary care provider.
    - Support the patient in his or her interactions with primary care provider.
    - Review and help the patient understand any changes or new information from the visit, and support implementation of those changes.
    - Encourage the patient to make contact primary care promptly when new health issues or red flags arise.
- Accompany the patient to specialty care or community-based appointments if needed and help the patient advocate for services on their own behalf.
- Conduct motivational interviewing and health coaching to support behavior change.
- Provide care coordination services.

- Work closely with the primary care provider and health plan care managers to address all components of the TOC discharge plan over the course of the month, thereby avoiding duplication of effort.

Through this relationship-based, intensive care coordination approach we will increase the likelihood that patients implement changes post discharge, reconnect in a timely manner with their primary care providers and specialists, and are linked to home health and social service providers to optimize the likelihood that they will avoid readmission to the hospital. Clients will be disenrolled following handoff to a longitudinal provider (e.g. primary care provider), when the client's risk is deemed low enough for discharge, or when the client refuses or does not engage in services. Clients enrolled in TOC services will not be enrolled in any WPC-LA care coordination programs concurrently.

The TOC program will operate out of each of the eight SPA based RCCs and operate under one set of administrative and operational policies and procedures to ensure integrated and coordinated services.

Service teams /provider network: Of the 25 LPS-designated, there are currently 4 LPS-hospitals in LAC on LANES, with numerous others planning to join in the coming years. We anticipate that the WPC-LA TOC program may be expanded in future years to include additional hospitals that meet criteria as defined above.

The WPC-LA team that will deliver this intervention will be comprised of a CHW, MCW and licensed clinical social worker (LCSW). The role of the CHW is described in the text above. The role of the MCW is to help the CHWs navigate complex housing and social service systems, support non-clinical patient assessments, and connect patients to key resources that support safe transition to the community. The role of the supervising SW is to oversee transitions of care discharge plan development and to provide clinical support to the CHW and MCW around behavioral health and social services, as necessary. The TOC team will receive general clinical support, and support for overall program implementation, from the overall WPC-LA medical director.

Prior experience/expertise: The TOC project will draw on DHS's experience utilizing 25 CHWs to support hospital-to-home care transitions for high risk populations, specifically individuals who have two or more hospital admissions or four or more ED visits in a 6-month period, or specific high-risk chronic medical conditions. DHS uses a protocol that was developed by two DHS physicians, Dr. Clemens Hong and Dr. Heidi Behforouz, who lead the DHS-CHW program – Care Connection Program (CCP). Dr. Clemens Hong is a nationally recognized leader and speaker in complex care management with multiple publications delineating best practices in care management, with a focus on the role of CHWs. Dr. Behforouz, a nationally recognized leader in the integration of Community Health Workers onto health care delivery teams, worked for over 15 years in inner city Boston, using a CHW model to provide complex care management services for high-utilizing AIDS patients in culturally and linguistically diverse community.

We will also draw on the experience of Partners in Care, an LAC-based non-profit that holds contracts with numerous hospital providers and health plans to provide TOC services using CHWs. In a population of 839 high-risk, Medicaid managed care beneficiaries, the Partners in Care model achieved a 41% reduction in 30-day readmissions rate (19.8% vs 11.6%). The two approaches are similar, and parallel the evidence-based approaches used in the IMPaCT model developed by Dr. Shreya Kangovi at the University of Pennsylvania.

Plan-Do-Study-Act approach: Throughout the implementation and development activities, WPC-LA teams will work within DHS and across collaborating organizations to test and implement system and practice changes that support achievement of desired outcomes using the PDSA process. For the TOC program, the TOC LCSW based at the RCC, will spearhead this process with support from improvement advisors based in the WPC-LA Hub. The LCSW will work with TOC CHWs and MCWs to collect data, identify areas of improvement, and implement changes to improve the plan. The group will meet on a monthly or every other month basis to plan tests of change and review completed test results. The group will use quantitative and qualitative data from tests to determine when to change directions and when to make changes permanent and sustainable. The team will share the results of their improvement efforts in regular reports to regional leadership and county administration.

Integration and care coordination: The CHW will serve as the lead care/case manager while the patient is in the hospital. For eligible patients that agree to participate in the TOC program, the TOC team will be the main point of contact for the month of patient enrollment. The CHW will visit the patient in their home and accompany the individual to appointments, based on protocols designed for the DHS CCP. At the end of the engagement, the TOC team will hand off remaining aspects of the care plan to the primary care-based care management team or the health plan care manager. The TOC team will clearly describe the process to the patient and ensure that they understand the transitional role of the TOC team within the patient's larger care team. The beneficiary will have contact with the same CHW for all of their needs during the course of the TOC intervention. The TOC team will serve as a liaison with the health plan and the beneficiaries' primary care team, ensuring appropriate handoff to longitudinal care managers. The TOC program will emphasize the coordinating role of the TOC care managers in creating a comprehensive care plan and working closely with other care team members to establish a continuous relationship with a longitudinal provider.

### Target Population 6: High Risk Expectant Mothers: MAMA's Neighborhood

The MAMA's Neighborhood program will offer comprehensive care management services based in a Mobile Care Team (MCT) aimed at providing wraparound services for those women who are pregnant and at high risk for substance use, social stress including violence, homelessness and food scarcity as well as mental health conditions that are associated with adverse birth outcomes. We aim to provide care to help mitigate the impact of these stressors for high-risk women, optimizing the likelihood of healthy births.

Service Teams/Provider Network: Working through social service agency partnerships (both private non-profit and public), our community-based healthcare teams will provide comprehensive, continuous and coordinated perinatal health services. These networks will provide care within the social, behavioral, mental and physical health risk domains which will be identified on a comprehensive intake assessment. Through care management by interdisciplinary and culturally competent teams, MAMA's will partner with expectant mothers to access services aimed to optimize perinatal outcomes.

MCT staff members will be working with established street teams to visit shelters, sobering centers, community clinics, faith based charity centers, food banks and jails, to identify women of childbearing age who may be or are pregnant. We recognize that the most vulnerable of the target population may have significant barriers to finding sites of care. Outreach staff will provide a basic assessment at the point of contact to connect women with the SPA MCT. They will also provide immediate navigation services to local food, housing and other social services as identified during the initial contact.

Staff will also work with women who are inmates in jails and prisons who are pregnant and will be released while pregnant and likewise those that are in institutions for mental health for more than 24 hours. Outreach staff will consist mainly of staff that do not have the licensed credentials or meet the educational or work experience required of case managers per the case manager qualifications as specified in Section 51272 of the 22 CCR. We will attempt to fill some if not all of these positions with those in the community who have a shared "lived experience" with the client population we are targeting. We have teams to bolster safety in the field and to approach groups of potential clients.

We will have staff grouped into MCTs that service each of the eight Los Angeles County SPAs. These MCT will consist of non-licensed Care Coordinators and 2 licensed staff: a nurse (RN) and a therapist (MFT or LCSW). Each staff member will be responsible for multiple tasks. The MCT will have standing case conferences with both medical and mental health clinicians to guide care delivery and provide consultation. Most activities and interactions of the care coordination teams will not qualify under Medi-Cal's TCM.

Care Coordinator (CC)
The CC, a community health worker, will use the intake assessment and risk stratification to develop the individualized care plan (ICP) and provide the direct assistance to clients. The CC not only discusses needed services identified but will also assess the clients readiness to address her needs. Then there will be a ranking and prioritizing of the needs and a proactive real time linkage to the resource in the presence of the client when possible. The CC will work collaboratively with the other members of the MCT to provide individualized follow-up care.

Registered Nurse (RN)
The RN's time will be divided between client encounters and managerial duties. There will be some face-to-face encounters with clients individually and during group health education classes held at the SPA office or other identified locations. The RN will facilitate coordination with the rest of the MCT and also serve as the managerial lead. Other duties include staff training, reviewing and modifying the ICP after the CC has completed it, and consultation regarding care management with the LCSW/MFT.

Behavioral Health (LCSW/MFT)
The mental health provider, when not providing direct patient care, will work in tandem with the RN to provide assistance managing and supporting the day-to-day work of the CCs and CLs. The LCSW/MFT will also provide primary support to the CL in identification of community resources, referral and connections to community care for social needs. The LCSW/MFT will be responsible for organizing and conducting the monthly collaborative care meetings.
Prior Experience/Expertise: WPC–MAMAs will draw on the experience we have gleaned with MAMA's Neighborhood, the three-year CMS-funded demonstration program at DHS which focused on linkages between the health system and community-based agencies to improve wraparound services for pregnant women, beyond the scope of traditional medical care. Central to the effectiveness of MAMAs population health management was the initial risk stratification through the use of an evidenced based comprehensive assessment that provided an Individualized Care Plan (ICP) which helped guide service integration. Another critical component of the MAMAs model was that the licensed and non-licensed staffing structure was able to integrate the clinical and psycho-social services provided in monthly collaborative care meetings.

While the program has been successful for women with access to health centers, a service gap continues to exist for many women in the community who do not come into our clinics as access to care is limited and the potential to improve health and birth outcomes is great. These women fall into the high-risk target population described above. The WPC-MAMA's model creates a synergy between the data driven collaborative care of the existing MAMA's Neighborhood model with the intensive case management of home-visitation, thereby extending the reach of both programs to hard-to-reach or previously ineligible clients.

Plan-Do-Study-Act Approach: In collaboration with our DHS and non-DHS partners we will practice a process evaluation model – first piloting an evidence-based strategy adapted for our population then revising that strategy toward maximizing healthy birth outcomes. The process will take place within and across MCTs. Within each MCT staff and their local community partners will meet monthly to discuss performance data on their progress toward a standard set of operational goals that are suitable for their geographic communities. Data will include ongoing tracking of community partner and patient contact; referrals made, accepted and used; and operations efficiency. MCTs will agree to strategy changes before introducing them into their respective communities. Each MCT will be responsible for summarizing strategies and any adaptations in reports and sharing those developments to the larger MAMA's community during quarterly meetings.

Integration and Care Coordination: The MAMA's collaborative care model is robust involving social workers, mental health therapists and culturally competent community workers (Care Coordinators) in a care team with nurses and physicians to direct the individualized care plans of clients. Collaborative Care meetings will allow the SPA MCT to combine the gathered knowledge of their highest need clients and integrate this information to facilitate the most appropriate way to delivery of wraparound services. Each team member will be providing services in different capacities thus the collaborative care meetings will provide a cohesive way to deliver care coordination and avoid duplicative services. During the collaborative care meetings there will be the opportunity to provide supervision and training for the non-licensed staff. The Medical Directors of the program – Obstetrician, Psychologist and Psychiatrist – will oversee all collaborative care team meetings to facilitate appropriate care and responds to clinical needs of clients in conjunction with the health system.

We will also periodically have care management meetings across SPAs to learn from and share best practices across the county. These meetings will be a space for peer support, trust-building, motivational support, ongoing on-the-job education, and staff development in a multitude of topics that affect clients such as trauma informed care, co-occurring disorders, and how adverse life events contribute to the psychosocial and psychiatric issues that contribute to our clients' situations. We will include representatives of the referral agencies the MCT's are working with to provide educational trainings.

The licensed team members will also liaise with medical and psychiatric teams to provide crisis intervention/consultations when required. They will ensure non-licensed staff are kept abreast of best practices, issues and incidents, as well as crisis assistance planning that is immediate and medical in nature.

Additional Service: Medical-Legal Community Partnership

The Medical-Legal Community Partnership (MLCP) will reach across WPC-eligible populations, using existing WPC workflows and teams to universally screen and provide targeted assessments with subsequent referrals for legal interventions. By providing additional expertise and take referrals for legal issues that are outside of the scope of practice for existing staff, MLCP will meet the legal needs of the client to benefit of the patient, their family (if applicable), the public healthcare system, and the wider community. The MLCP, staffed by community legal service providers with attorneys and paralegals who currently provide these types of services in other settings, will provide training for the WPC staff to allow them to build upon their existing skill and utilize the WPC assessment and existing patient/client interactions to identify opportunities for intervention through an augmented assessment. The range of legal remedies provided will include but not be limited to:

- Health coverage and access to health care
- Consumer debt, medical debt, and foreclosure
- Nutrition and income supports
- Barriers to employment
- Housing insecurity and poor housing conditions
- Criminal matters and tickets
- Immigration matters
- Domestic violence and personal safety
- Family law and child custody

The MLCP teams will be funded through incentive payments, as detailed in the Incentive Payments section of the Budget Narrative.

## 3.2 Data Sharing

### Whole Person Care (WPC) Data Sharing Plan

We will leverage and build upon County-run and County-wide data analytics and sharing initiatives to address programmatic needs for WPC-LA and develop a sustainable infrastructure to support data sharing between participating entities. WPC-LA will expand key tools, bring data together, strengthen data analytics infrastructure, and accelerate data sharing initiatives in order to address fragmentation of care and improve health outcomes for patients in the LAC safety-net.

### County-run Initiatives

As the largest single provider of care in the safety net, the LAC Health Agency has led care and plan partners in developing data sharing tools. The Health Agency is implementing a new enterprise data warehouse, a new master identifier for patients, and a health information exchange to bring together physical, behavioral, and corrections health data for analytics and care improvement among County-run departments. This infrastructure will be critical for the success of WPC-LA.

#### Electronic Health Record (EHR) Systems

DHS, DMH and Jail Health have each recently implemented EHR systems. DMH's EHR, IBHIS, is implemented in all directly-operated DMH clinics. It provides Client Web Services that enables electronic information exchange between IBHIS and the electronic health record systems of DMH's contracted partners and hospitals. DMH also exchanges referral and clinical information with non-County primary care providers. In WPC-LA PY2, it will expand its electronic exchange of PHI with DHS and DPH-contracted agencies that provide addiction treatment services. IBHIS's existing approach to data exchange may also be enhanced through the use of software that accepts PHI from many electronic health record systems to create a consolidated view of the client's status and care provided across multiple agencies/providers.

The Sheriff's Department and DHS both implemented Cerner Millennium products in the Jail Unit and across all DHS sites, respectively. With client permission, care members from other entities (e.g., Recuperative Care Centers, Sobering Centers, and DMH staff) will be able to view records in DHS' EHR (named "ORCHID"), including discharge summaries, test results, and medication lists. In addition, DHS will expand the population management capability of ORCHID in the coming years through Cerner's HealtheIntent population health module. For WPC-LA patients receiving primary care at DHS, HealtheIntent will support patient tracking and care management.

Timeline and Future State: All three EHRs are already live at County-operated facilities. IBHIS Client Web Services will be implemented by Spring 2018. DHS HealtheIntent's launch is targeted for Spring 2017.

#### DHS Enterprise Data Warehouse – CEDAR

CEDAR (Comprehensive Enterprise Data and Analytics Repository) is an enterprise data warehouse designed to optimize data analytics for program process and outcome monitoring and evaluation across the Health Agency. CEDAR already integrates clinical data from the DHS' ORCHID; data on Medi-Cal eligibility, out-of-network claims, and pharmacy fills from the two Medi-Cal health plans in LA County; specialty referrals in eConsult (a countywide electronic consultation platform), and financial data.

Timeline and Future State: Planned CEDAR expansion in late 2016 will provide data visualization tools and dashboards for all clinical staff at DHS and ad-hoc query capability. The LAC Health Agency is pursuing the expansion of CEDAR to incorporate medical, behavioral and jail health data for the purposes of improved WPC analytics. Challenges related to this expansion include addressing technical requirements such as robust patient identity resolution across these data silos and regulatory and data governance considerations with the use of behavioral and correctional health data. WPC-LA will help LA County address both of these challenges as described below.

Patient Identity Resolution software – Countywide MDM

The ability to accurately and reliably merge patient records from multiple data systems for a single individual is a fundamental requirement for data analytics and data-sharing that the County Wide Master Data Management (CWMDM) project will address. The WPC-LA will provide critically needed funding and support for implementation of CWMDM across the Health Agency.

Timeline and Future State: InfoSphere is now live at DHS and DMH. Through WPC, we will expand identity resolution capability with Jail Health, Probation, and SAPC.

## Countywide Initiatives

Data sharing for care delivery and coordination beyond County-run health facilities requires health information exchange among County and non-County entities including private hospitals, community partners, FQHC clinics, and Medi-Cal health plans. These county-run initiatives are necessary but not sufficient to provide a comprehensive view of a client for WPC-LA. These systems must be integrated into county-wide data integration approaches that provide access to data from non-county facilities and health plans to be useful for WPC-LA.

Los Angeles Network for Enhanced Services (LANES) -- Health Information Exchange (HIE)

LANES provides the data foundation for all WPC-LA activities. The LANES HIE is a non-profit organization whose mission is to improve health care delivery by providing a platform that enables cost-effective and secure electronic exchange of patient medical records among public and private health care providers and plans across LA County. LANES intends to be the singular and comprehensive HIE platform for the entire safety-net.

LANES' key capabilities include real-time encounter notification services including the automated delivery of clinical documents (e.g., discharge summaries, radiology reports, etc.) to end-users and longitudinal aggregate patient record information viewable via secure web-accessible portal or within the end-user's own EHR. LANES has contracted with Mirth Corporation to provide HIE software services. The LANES database will include admit/discharge/transfer (ADT) encounter information, problem lists, allergies, medications, immunizations, lab results, and transcribed notes, including summary-of-care documents, histories and physicals, discharge summaries, specialty consult notes, and radiology reports.

Timeline and Future State: A Board of Directors that includes the County of Los Angeles, the Hospital Association of Southern California, L.A. Care Health Plan, and the Community Clinic Association of Los Angeles County governs LANES. Through a phased implementation approach over the next 3-4 years, LANES intends to connect all hospitals and clinics that predominately provide care to the safety net and

the large Medi-Cal health plans (L.A. Care, Health Net, and Molina) by the end of 2018. DHS, DMH, L.A. Care Health Plan, and a set of private hospital groups and FQHCs are targeting late 2016 or early 2017 for launch on the LANES platform. We will leverage WPC to help ensure that additional county entities, providers and health plans join. The LANES Support Program will help ensure that additional county entities, providers, health plans, and community clinics join by providing a LANES annual subscription fee discount for these entities to offset the cost they incur for adopting LANES. The incentive payments for connecting these entities to LANES are detailed in the Downstream Provider Incentives section of the application. We anticipate that LANES will ultimately be able to add community based organizations and social service providers. Data integration will not be complete at the launch of WPC-LA, but a strong foundation will be in place.

Care management platform

In order for WPC-LA to be successful and meet all program requirements, a robust care management platform (CMP) is required. Because of the countywide nature of WPC-LA, this CMP will be anchored to LANES. Integration with LANES will enable provider entities across the county to access key information on care plans and care management encounters.

CMP will have mobile capability, allow field-based documentation, enable communication and task sharing between WPC team members and with other non-WPC care teams, allow access to information, including the care plan, information from prior encounters with WPC care team members, and clinical information from LANES. The platform will house an open and accessible care plan for each WPC client and will allow providers across the county, with appropriate permissions, to see and contribute to the care plan of a WPC client. It will require broad consent and a thoughtful IT solution, but it will break down care silos and allow a more integrated approach. WPC staff and contractors will work with other non-WPC care managers to ensure that an individual client has one care plan that is maintained within the CMP.

This custom built platform will be critical to WPC-LA operations, will draw data from multiple sources, and will be the primary tool that WPC teams use to perform their duties. WPC staff will use CMP at the point of engagement to confirm program eligibility and obtain consent for program participation and data sharing. The consent process will be carefully designed with input from participating entities, community members, and legal counsel. We will pay particular attention to developing an acceptable consent process for WPC clients who may have low literacy, limited English proficiency, and cognitive, visual, and other functional impairments (including conservatorship). WPC clients will be able to specifically delineate which providers have access and to which available data types. We will build low-literacy tools to support the consent process. WPC staff will be extensively trained and monitored to ensure quality.

All entities providing care to WPC-LA clients (with appropriate permission), including health plans, providers and community partners, will have access to CMP and the data collected within it. The CMP will have continuous, bidirectional linkages to the LANES HIE that will allow information to flow into the CMP (e.g., Admission/Discharge/Transfer feeds) and out to partner entities (e.g., care plans, updated client contact information, or care management documentation). We will make CMP data available to entities that use their own native care management platforms and electronic medical records through LANES. For entities not on LANES, we will explore opportunities to provide data directly through our CMP vendor.

WPC will work with the LANES Board to establish approved use cases of LANES HIE for care-management and related analytics needed for WPC interventions. WPC use cases will require LANES HIE to expand the existing scope of services by a) granting system access to non-traditional health care providers such as CHWs as well as to community-based service organizations, b) integrating behavioral health and correctional health data, c) offering database access for analytics on WPC metrics, and d) providing or integrating with CMP.

Timeline and Future State: The CMP is expected to be operational by March 1, 2017. Because most LANES Board members and large participants including L.A. Care Health Plan are also participating in the WPC, we anticipate that the LANES HIE will make the necessary modifications to current data use agreements and system functionality.

Bidirectional Data Sharing with Health Plans

Data sharing between DHS, county entities (e.g. DMH, the Sheriff Department, DPH), and the health plans will be critical to the success of WPC-LA. Most key operational data and process measures for quality improvement will be collected through the care management platform, as described above. We will make this information accessible to all of our partners, including all Health Plans and their care coordination teams, through interval (e.g. monthly) aggregate reports and direct access on a client basis, with appropriate permissions, through CMP.

Currently, L.A. Care and HealthNet already share data with DHS and DMH on shared Health Plan members that receive care through county operated and contracted clinics. We will build upon this infrastructure to include beneficiaries eligible for and receiving care through WPC programs and work toward achieving real-time access to key data elements.

Timeline and Future State: Over the course of the pilot, we will engage all health plans in bi-directional data sharing. As described above, we will use the linkage between LANES and the CMP to ensure bidirectional flow of information between Health Plans and county entities through the WPC pilot. Although we anticipate progress towards data sharing goals prior to January 2017, we anticipate a need to work closely with health plan partners, LANES, and county entities to accelerate the process. We will form a WPC data integration & analytics workgroup, including broad representation, to ensure that we address barriers and work through steps necessary to achieve our goal of real-time, bidirectional data sharing.

In addition to the components outlined above, several WPC-LA programs will utilized niche systems that contain features targeted to specific program or population needs. These systems are detailed in the sections describing those WPC programs.

Key data sharing challenges and potential remedies are shown in Table 3.2a.

Table 3.2a: Data Sharing Challenges and Remedies

| Challenge | Remedy |
|---|---|
| Ensure that sensitive information is not shared without clients' permission | 1) Work with County Counsel to develop a universal consent form that clearly explains the reasons data may be shared, and identifies which data may be shared, with whom, and for what purpose |

| | |
|---|---|
| | 2) Train program enrollment staff to ensure that clients fully understand the consent and that each client signs the consent prior to any data being shared |
| Ensure appropriate regulatory compliance with use of behavioral and corrections health data in LANES HIE | Work with LANES and Mirth Corporation on provisioning end-user access for approved staff only to behavioral /correctional data in compliance with regulations. |
| Provide LANES HIE database access for analytics for WPC. (In current LANES data-use agreement, use of the database for programmatic evaluation/analytics is not permitted.) | Work with the LANES Board and participants on amending the LANES Data Use agreement |
| Provide Care Management solution that is easily adopted and operated by CHWs and other CBO staff | Work with LANES/Mirth or other vendors to custom design and build a care management tool that integrates with LANES HIE |
| Address disconnect between DMH and DHS clinical information | Build both relational and data exchange connections that allow for effective and consistent data exchange on high-risk patients involved in LPS care transition or PES decompression programs; consider creating and using an MOU |
| Comply with stricter rules for information-sharing on SUD treatment as compared to physical health or mental health | 1) Develop and implement universal consent (see above)<br>2) Utilize Health Agency staff (who are allowed to see PHI) to aggregate data results for reporting |
| Consider the limited IT infrastructure at SAPC and SUD-contracted providers to facilitate electronic reporting | Monitor progress in the field. For example, SAPC is currently investing in data reporting infrastructure through the LA County Participant Reporting System (LACPRS) and is also procuring a managed care information system to track additional outcomes. |

Sustainability and Governance

WPC-LA will leverage but also help expand the scope and functionality of already existing data analytics and data-sharing infrastructure in Los Angeles County. To achieve this, the WPC initiative will engage existing governance mechanisms of each of the tools described above. The County and non-County tool sets are each governed by entities who are also anticipated participants in WPC-LA. The Countywide MDM Steering Committee and the LANES Board of Directors will serve as primary governing sites for incorporating the needs related to data analytics and data sharing for the WPC. In addition, WPC-LA's governance structure will include a workgroup on data governance (within the data and evaluation subcommittee), to ensure that data definitions are standardized and reporting methodologies are consistent across participating agencies.

All WPC-LA data sharing will comply with applicable state and federal laws related to sharing of Personal Health Information/Personal Information (PHI/PI), mental health or substance use disorder services information. DHS contractual and data sharing agreements with vendors and service providers include specific language regarding required compliance with the Health Insurance Portability and

Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH), and applicable state and federal laws.

Unique Target Population Data Sharing Components

Each WPC-LA program will utilize the full array of data sharing components outlined above in the WPC Data Sharing Plan, including electronic health records, client identity resolution, health information exchange, and a care management platform. This next section describes the unique aspects of data sharing for each target population and describes key data elements that will be shared through this infrastructure.

## Homeless High-Risk Data Sharing

The Homeless High-risk Program will require applications designed to address the particular needs of housing and homelessness services and these unique service providers.

Housing and Bed Management

For Homeless high-risk clients, staff will utilize ClientTrack – a web-based application that enables management of client intake from all referral sources, support triage and matching to appropriate service types (e.g. recuperative care, Homeless Care Support Services, SSI advocacy, etc.), and provide relevant and authorized information exchange between DHS Housing for Health and service providers. The WPC pilot will use ClientTrack to share housing data between participating entities.

Timeline and Future State: ClientTrack will be deployed by January 1, 2017 and will be available to partnering agencies following a rigorous training, including robust training manuals, in person training, train-the-trainer programs, and help desk support. ClientTrack is scalable and sustainable and will be used to support services provided to homeless clients beyond the term of the WPC pilot. ClientTrack and WPC-LA CMP will have an interface. Goal will be to reduce duplication of double documentation.

Access to Housing

The Coordinated Entry System (CES) is a countywide platform administered by the Los Angeles Homeless Services Authority (LAHSA) to ensure that each client has equal access to permanent housing opportunities. CES creates a no-wrong-door system that spans street outreach, homeless service sites, clinics, volunteer locations, and many others. CES provides a regional infrastructure for coordination, a common intake tool and a common database.

The Vulnerability Index-Service Planning and Decision Assistance Tool (VI-SPDAT) is a CES-embedded, evidence-based survey tool that assesses a client's vulnerability and recommends what level of housing intervention and resources would optimally meet the client's needs. The VI-SPDAT meets all federal guidelines of a common assessment tool and gauges housing and homeless history, risks, socialization, daily functioning, and wellness.

Information collected through VI-SPDAT is entered into the Homeless Management Information System (HMIS) database, a secure, web-based platform that is available free of charge to participating agencies. HMIS helps match resources to eligible clients. Approximately 17,000 clients have completed the VI-

SPDAT and have records in CES. Over 100 agencies that provide services to people who are homeless use CES, including community-based homeless services providers, shelters, DMH, and DHS.

These combined tools allow dynamic and real-time prioritization of the most vulnerable client to the next available resource that meets their needs. Each WPC-LA program will refer homeless clients to Housing for Health, and a Homeless Care Support Service worker will use this system to navigate the client to housing and other resources they need.

Timeline and Future State: The CES is already operational and in use by LAC DHS and DMH staff. The platform will continue to be used beyond the term of the WPC pilot.

### Justice-involved High Risk Data-Sharing

In addition to the data sharing components outlined in the WPC-LA Data Sharing Plan above, WPC-LA staff will identify individuals who are nearing release using the Sheriff's Automated Justice Information System (AJIS) to identify inmates who are scheduled for release within the next 90 days, as well as those who have been recently released.

Clinical staff currently working as part of jail health document in the Jail's EHR, Jail Health Information System (JHIS). WPC-LA will develop a custom discharge plan within JHIS to facilitate the discharge planning process and referrals to the WPC-LA re-entry program. The discharge plan will contain relevant information from the jail stay including clinical information. Initially, WPC-LA teams will print the discharge plan for the client; eventually, the plans will be viewable by post-release teams in the CMP, and by community-based providers through LANES.

### Mental Health High-Risk Data Sharing

The most significant type of information exchange will occur among WPC-LA team members. DMH's existing internal information systems allow for the free exchange of information among RBC and ISR team members. They will also have extensive personal communication through meetings and telephone conversations with community partners involved in delivering coordinated care.

Multi-disciplinary WPC-LA teams will use data from acute hospitals to identify eligible clients.
The RBC transitions team will need to access DMH data from acute hospitals, IMDs, and ERS providers to identify individuals eligible for the project. The information will include diagnoses and the number and nature of prior in-patient stays, as well as information typically contained within an adult initial assessment, and current clinical and treatment information regarding enrollees. DMH's Information System (IS), which can be accessed both by the acute hospitals and the multi-disciplinary teams, contains all of the necessary information required for this function. IS will be replaced by the Integrated Behavioral Health Information System (IBHIS) which will contain the same clinical information.

WPC-LA teams will also need to share protected health information (PHI) with staff from DHS and DPH-SAPC. DMH will share PHI with DHS's EHR through a Continuity of Care Document (CCD) that contains clinical information required for care coordination. SAPC representatives on the team may become volunteers of DMH and will thereby gain access to data. Although clinical team members will predominately depend on the EHR, other WPC team members will have access to CMP for care management tracking purposes, as necessary.

Finally, WPC teams will need to share data with other DMH program staff, community mental health and health agencies, and other essential providers that will offer an array of services to enrolled clients. This will include all information typically contained within an adult initial assessment and current clinical and treatment information regarding enrollees. With permission, some of this information, including the care plan, will be made available through CMP.

### Substance Use Disorder (SUD) High-Risk Data Sharing

Because there are specific regulations governing the sharing of substance abuse treatment data, consent to share information with the care teams will be explicitly addressed with clients as part of the initial enrollment and opt-in process. This will be critical to ensure that the program can receive information on referral outcomes and treatment adherence, for both individual case monitoring and overall performance monitoring.

Contracted SUD providers provide data and regular reports to SAPC on new clients and services provided using SAPC's information system, the web-based LACPRS. However, data entered into this system is limited to dates of service and billable services. SAPC plans to implement a new electronic managed care information system that will capture provider notes and other details on client encounters. This system will be available by July, 2017.

WPC teams will use the CMP to collected key referral information. SAPC providers will have access to CMP; however, because CMP may not be embedded in their workflow, we will work with SAPC providers to develop workflows that allow for transmission or sharing of data collected by WPC teams to SAPC providers for further management.

### Medically Complex Data Sharing

The WPC TOC team will require ADT and historical data feeds through LANES to identify patients for intervention. Alternatively, Health Plans may leverage their electronic data repositories to identify eligible patients in LPS hospitals. The WPC TOC teams will be notified through these two mechanisms, whenever a patient meets the patient selection criteria of three or more admissions in a six-month period. The WPC TOC teams will then engage the hospital team and/or the patient to determine whether the patient meets remaining eligibility criteria. WPC TOC teams will perform their care management activities with support from CMP.

## 4.1 Performance Measures

WPC-LA will take a data-driven, performance improvement-focused approach to examining the innovative work of this pilot program in LAC. The performance measures selected across both universal and variant metrics have wide applicability to the target populations of WPC-LA and will help place relative value on each of the tools that are a part of the WPC Toolkit. The selected metrics will guide how tools and strategies in each program can and should be modified. We have specific health outcome metrics that are familiar to many WPC-LA participating partners. These metrics will require data to be shared between many participating entities and community partners. Because a significant amount of WPC-LA data will be housed in the CMP, the CMP is not only a strong clinical documenting and management tool but also a powerful data repository for guiding WPC-LA.

### Universal Metrics

Table 4.1a, delineates the Universal Metrics that will be followed in WPC-LA. The checkmarks below acknowledge our responsibility to track and report the following types of universal metrics as required in the application.

☒ Health Outcomes Measures
☒ Administrative Measures

Table 4.1a: Universal Metrics

| Measure | Goal for Metric by Program Year (PY) | | | | |
|---|---|---|---|---|---|
| | PY1 | PY2 | PY3 | PY4 | PY5 |
| Submission of Policies and procedures across the WPC-LA lead and participating entities which provide for streamlined beneficiary case management – all participating entities must have timely access to beneficiary information for care coordination and case management, and it must establish a communication structure for participating entities | N/A | Yes | N/A | N/A | N/A |
| Submission of documentation demonstrating establishment of a data and information sharing policies and procedures across the WPC-LA participating entities. | N/A | Yes | N/A | N/A | N/A |
| Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days of: 1) enrollment into WPC, 2) beneficiary anniversary of participation | 0% | 1) 20%<br>2) N/A | 1) 40%<br>2) 40% | 1) 60%<br>2) 60% | 1) 80%<br>2) 80% |
| ED utilization: The number of emergency department (ED) visits during the measurement year | Baseline | Maintain baseline | 5% reduction | 7.5% reduction | 10% reduction |
| Inpatient Utilization: The number of acute inpatient discharges during the measurement year. | Baseline | Maintain baseline | 5% reduction | 7.5% reduction | 10% reduction |
| Follow-up after Hospitalization for Mental Illness: The percentage of patients who received follow-up within 30 days of discharge. | N/A | 50% | 55% | 60% | 65% |

| | | | | | |
|---|---|---|---|---|---|
| Initiation and Engagement of Alcohol and other Drug Dependence Treatment:<br>• Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.<br>• Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. | N/A | 1) 50%<br>2) 60% | 1) 55%<br>2) 65% | 1) 60%<br>2) 70% | 1) 65%<br>2) 75% |

## Variant Metrics

Table 4.1b, details the proposed variant metrics that WPC-LA will follow for each target population, and the accountable participating entities for each metric. Table 4.1c, delineates the vision and rationale for each variant metric.

Table 4.1b: Variant Metrics and Accountable Participating Entities

| Target Pop | Metric type | Metric | Accountable Participating Entities | Goal for Metric by Program Year (PY) | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | PY1 | PY2 | PY3 | PY4 | PY5 |
| All Target Populations and Programs | Admin | Hold monthly WPC leadership meetings | All Participating Entities | N/A | Yes | Yes | Yes | Yes |
| | Health Outcome | 30-day All cause readmissions (DHCS External Accountability Set: Administrative non-NCQA measure: defined by ACR collaborative) | DHS, DMH, SAPC, Health Plans[1], Community Re-entry Partners[3], HCSS Partners[4] | Baseline | Maintain baseline | 5% reduction | 10% reduction | 15% reduction |
| | Health Outcome | Jail recidivism | DHS, DMH, SAPC, LASD, Probation, Community Re-entry Partners[3] | Baseline | 5% | 6% | 7% | 8% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Housing | Proportion of clients housed by WPC who are permanently housed for >6 months | DHS, DMH, SAPC, LASD, Probation, Health Plans[1], Housing Authorities[2], Community Re-entry Partners[3], HCSS Partners[4] | N/A | 75% | 80% | 85% | 90% |
| Mental Health High-Risk | Process | Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) | DHS, DMH, LASD | N/A | 40% | 50% | 60% | 70% |

[1] Health Plans – LA Care, Health Net, Anthem Blue Cross, Care1st, Kaiser, Molina

[2] Housing Authorities – Housing Authority of the County of Los Angeles, Housing Authority of the City of Los Angeles

[3] Community Re-entry Partners – LARRP Coalition

[4] HCSS Partners – Skid Row Housing Trust, Alliance for Housing and Healing, Downtown Women's Center, GettLove, Homeless Health Care Los Angeles, LifeSTEPS, Mental Health America, Ocean Park Community Center, Pacific Clinic, SSG/Hopics, St. Joseph Center, Step Up on Second, Volunteers of America – Greater Los Angeles, Watts Labor Community Action Committee

Table 4.1c: Vision/Rationale for Variant Metrics

| Target Population | Metric type | Metric | Vision/Rationale |
|---|---|---|---|
| All Target Populations and Programs | Admin | Hold monthly WPC leadership meetings | Shared governance and decision making is a fundamental aspect of WPC-LA. Monthly meetings with WPC-LA leaders will allow for regular progress reviews, problem-solving, course corrections. |
| | Health Outcome | 30-day All cause readmissions (DHCS External Accountability Set: Administrative non-NCQA measure: defined by ACR collaborative) | Across target populations, our patient selection approach will identify Medicaid beneficiaries who have a high likelihood of hospital admissions. All of our interventions will support clients at the point of discharge from the hospital with the goal of reducing readmissions. |

| | | | |
|---|---|---|---|
| | Health Outcome | Jail recidivism | Recidivism is a major societal problem. The WPC-LA re-entry program is robust and scaled for LAC's size. The notion that our health-focused interventions can impact recidivism is important to validate. This measure pushes us to address the confluence of health and social service issues that lead to re-incarceration |
| | Housing | Housing: Permanent Housing | A key goal of WPC-LA is to permanently house high-risk homeless individuals. This measure encourages us to achieve sustainable permanent housing for our clients. |
| Mental Health High-Risk | Health Outcome | Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) | We will work with a Seriously Mentally ill target population that has a high rate of depression. For this reason, suicide risk assessments in this population will be done consistently. |

Data collection and review plan

We will leverage our WPC data backbone and analytics infrastructure to track our universal and variant metrics. (See Section 3.2) The CMP will allow for the collection of critical information within the workflow of our WPC teams, information that would otherwise not be routinely tracked by other electronic databases. Data available through the CMP will allow real-time collection of key process metrics for use in performance improvement activities and program redesign. Other sources of data to be tracked include: partner health plan data, individual County department data systems (i.e., DHS's Orchid Electronic Health Record), LAC Homeless Information Management System (HIMS). Progress toward improvement will be reported and shared with frontline staff, program management and participating entities through monthly dashboards that are target population and program-specific. WPC program leaders and teams will use this rich, continuous data on performance to drive improvement and process redesign through PDSA cycles. The WPC leadership group will review the dashboard together at quarterly leadership meetings. Leadership will determine if additional PDSA process improvement efforts are warranted to add additional focus in a specific area.

## 4.2 Data Analysis and Reporting

The key tools driving continuous quality and performance improvement (PI) in WPC-LA will be collection of accurate, real-time data on process measures and outcomes, adherence to a quality improvement framework suitable for each intervention, analytic support in turning data into usable information, and improvement advisors to train, coach, and support front-line workforce in techniques and approaches that can lead to continuous improvement in program implementation.

Due to the innovative nature of programs in WPC-LA, we will invest in the creation of the CMP (See Care Management Platform in Section 3.2) that enables immediate collection of codified data on process and some outcomes measures in the field, and delivers information continuously to frontline staff and operational and administrative leaders to support program management and quality improvement efforts. We anticipate the CMP will be online by March 31st, 2017. During the initial months of program roll out, we will enter specific information related to process and outcomes metrics into an access database to ensure we capture complete data on reportable measures. For outcomes not collected reliably in the CMP, we will leverage our integrated data infrastructure (see Section 3.1 Data Sharing), prioritizing key outcomes for reporting, program management and quality improvement purposes. This continuous framework for data collection will enable reporting and rapid responses to DHCS requests for data on metrics. Initially, metrics will focus on operational and outcomes data. In Program Year 2, data analytics staff and PI staff will explore more closely how to collect information necessary to complete return on investment (ROI) calculations. WPC-LA intends to track ROI data over the course of each year within and across the different WPC programs. We expect that, with time, and as more clinical and community partners participate in WPC, the ROI will improve. If the ROI analysis is too sophisticated for the internal staff, we will recruit a contract group with ROI analysis experience.

Enhanced data collection and analytic capability will enable the WPC-LA leadership group and team leaders to regularly monitor the metrics described in Section 4.1 and to identify improvement areas for each target population. The analytics unit will provide data to WPC leaders, including RCC management, in monthly dashboards with relevant run charts, including data at the level of individual team members, to support a local assessment of performance and guide focused improvement efforts. We will work over the course of the pilot to make data available in real-time. Analyzing data shared on monthly dashboards, WPC leadership will work with their teams to identify gaps in services, programmatic challenges, and other areas requiring change and/or improvement. Teams will hold multidisciplinary PI meetings at least monthly in which they will create and execute change management plans, using PDSA cycles to improve and redesign processes as necessary in an iterative process.

The newly formed DHS Office of Performance Improvement (OPI) will be expanded in order to offer support to WPC-LA in the above activities. The WPC-LA dedicated resources within OPI will support all quality and performance improvement efforts by providing tools, training, and coaching needed to maximize the impact of WPC-LA efforts. This PI infrastructure provided by WPC-LA dedicated OPI staff will provide a strong foundation for performance improvement efforts, while the Plan-Do-Study-Act framework and Lean principles will provide the methodological base. WPC teams, with guidance from OPI staff, will review the dashboards relevant to their program at monthly, cross-SPA PI meetings. Improvement Advisors will also work closely with each RCC team to ensure the sound application PI methodologies to continuously drive improvement in care outcomes for WPC clients. Finally, OPI staff will lead structured improvement initiatives, (e.g., mini-learning collaboratives) that support training,

technical assistance, and system redesign, accelerating the rate of learning and helping to assure continuity and consistency of change across the pilot.

## 4.3 Participant Entity Monitoring

The lead entity, DHS, will identify a County Project Director and County Project Manager responsible for administering the agreements with WPC-LA participating entities. Specific duties of the county staff will include: monitoring participating entity performance in the daily operation of their agreement(s) and providing direction to the participating entity in areas relating to policy, information, and procedural requirements, as well as technical assistance. The County Project Manager, or designee, is responsible for evaluating ongoing participating entity performance, which will include assessing the entity's compliance with all agreement terms and conditions and performance standards. Standard LAC contract requirements call for contract monitoring to also include an annual on-site program review to assess adherence to the statement of work (including review of case management documentation for a sample of clients, if appropriate), a written report of findings, and requirement that the agency submit a plan of correction for all findings. The County Project Manager will make verbal and/or email notification to the participating entity project manager as soon as possible whenever a discrepancy and/or noncompliance with the agreement is identified. The discrepancy and/or noncompliance instance shall be resolved within a time period mutually agreed upon by the County and the participating entity.

Any performance deficiencies or agreement noncompliance which the County determines are severe or continuing and that may place performance of the agreement in jeopardy if not corrected will be communicated to the participating entity in writing with a request for an improvement/corrective action plan. If improvement does not occur consistent with the improvement/corrective action measures, the County may terminate the agreement or impose other sanctions as specified in the agreement.

## 5.1 Financing Structure

WPC-LA will be funded through an Intergovernmental Transfer (IGT) from the County of Los Angeles. The funds will consist of a $5 million contribution from the University of California, and the remainder will be County funds. The related WPC-LA payments will be paid to LAC DHS as the Lead Entity. LAC DHS will oversee the intake of funds and their disbursement within 30 days of receipt. WPC-LA payments will be distributed to the participating County agencies, including LAC DHS, the LAC Sheriff's Department, the LAC Department of Mental Health, and the LAC Department of Public Health, based on the success of each department in achieving those deliverables for which it is responsible. The distribution of WPC-LA payments among the County agencies will be tracked through LAC's eCAPS system, and subject to oversight by the LAC Auditor-Controller.

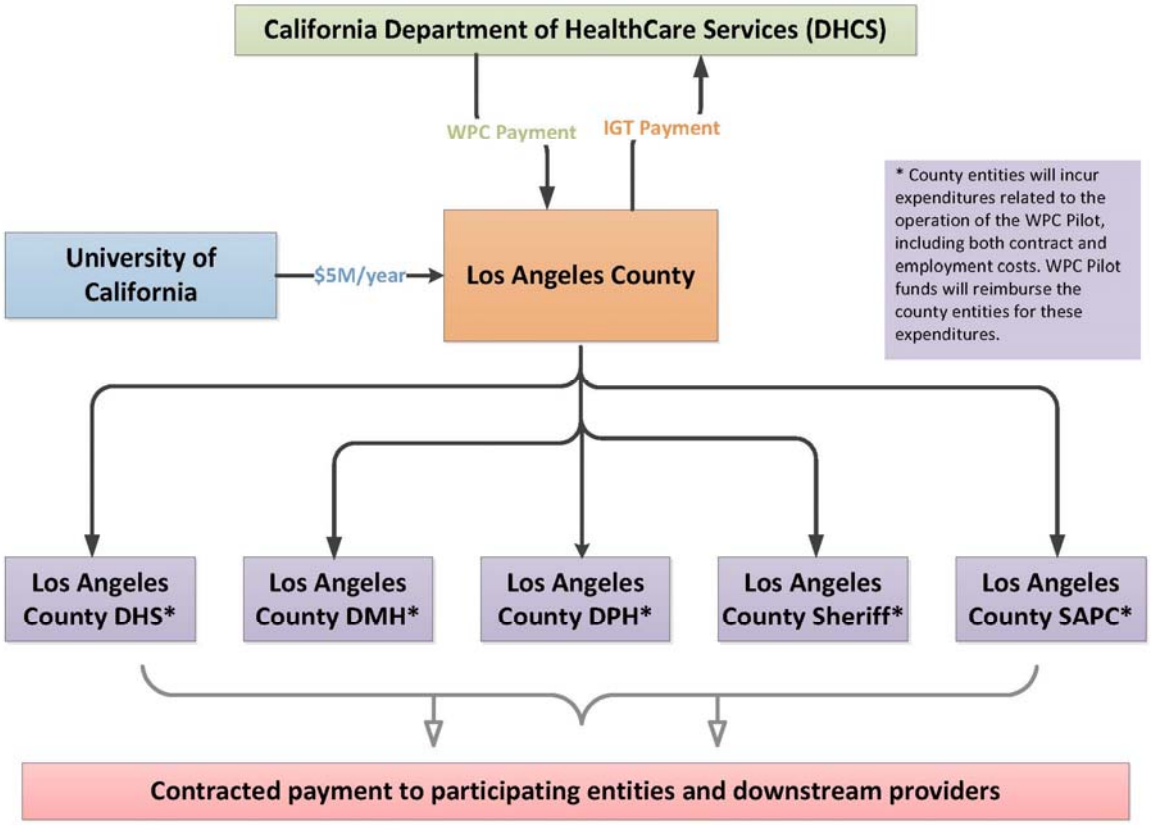
County agencies, as well as partners such as L.A. Care, will incur expenditures related to the operation of the WPC-LA, including payments to downstream providers and vendors of services (including both employment and contract arrangements). In some cases, partners such as L.A. Care will incur the expenditures for securing certain services from downstream participating entities, and will be compensated by LAC DHS based on their cost in doing so. WPC-LA payments from DHCS will reimburse the County agencies for these expenditures. Other than the inherent nature of the bundled payments described below, there are no savings arrangements built into the financial structure of WPC-LA.

The estimated cost value of WPC-LA services, including both employment and contract arrangements, are set forth in the budget documents accompanying this application. In the event changes to these estimates are necessary in the future, we will update the budget documents for subsequent years, to ensure that the requested WPC-LA funding levels are sufficient to meet the goals of WPC-LA.

WPC-LA financing and payment approaches include components that will directly help participating providers transition to value-based payments in the future, and will provide data that helps inform such transitions for Medicaid programs in general. WPC-LA will utilize various forms of bundled payments where participating entities are responsible for better managing care for high-risk, high-volume populations, and have an incentive to develop and adopt clinical or administrative efficiencies. In addition, incentive payments and reporting requirements will encourage the tracking of outcomes in key areas, such as reductions in emergency department visits, hospital admissions, and follow up after mental health hospitalizations, that could help inform future efforts related to value-based purchasing. WPC-LA will also develop a risk adjustment algorithm based on the data developed from the pilot, that can help better predict comprehensive pricing models for high-risk individuals, which is essential for the success of a potential future value-based payment program. In addition, the WPC-LA care teams dedicated to care support for the most vulnerable patients will provide a wealth of data and experience that can help participating entities succeed under value-based purchasing models, should such models be implemented.

## 5.2 Funding Diagram

The funding diagram below illustrates the flow of WPC-LA payments [See Section 5.1 for a narrative description].



## 5.3 Non-Federal Share

The entities that will provide the non-federal share of WPC-LA payments are the County of Los Angeles and the University of California.

## 5.4 Non-Duplication of Payment and Allowable Use of Federal Financial Participation

WPC-LA Budget payments will support the provision of services that supplement, but do not supplant, services currently available through the Medi-Cal program or through state or local obligations, as well as related infrastructure and other strategies intended to meet the goals of the WPC-LA. Specific steps we have taken to ensure non-duplication of services are addressed below.

Limitation to Medi-Cal Beneficiaries: WPC-LA will not include any individuals who are not eligible for Medi-Cal. To the extent activities developed under WPC-LA are extended to individuals who are not Medi-Cal beneficiaries, the costs associated with extending the services outside WPC-LA were excluded when developing the WPC-LA budget (including consideration of the case load in developing required staffing levels), and those individuals would not be considered part of the WPC-LA.

Services for Justice-involved High Risk Populations: WPC-LA interventions for the Justice-involved high risk population will create new interventions that are not currently available to Medi-Cal beneficiaries. The County's state law obligations to tend to the health of jail inmates only extends to emergency and basic health services, and is focused on managing health and mental health issues during incarceration. (15 Cal. Code Regs. sections 1200 and 1208.) The WPC-LA will focus on helping the sickest inmates to re-enter the community and supporting them for the initial months after re-entry to ensure they are stable in their communities. The WPC-LA is not seeking payment for services LAC is obligated to provide for its inmates.

Federal guidance clearly states that individuals may retain their eligibility for Medicaid even while incarcerated, notwithstanding the federal exclusion of most services to inmates from the definition of medical assistance. (See SHO #16-007, April 26, 2016). Many individuals in correctional facilities are eligible for Medi-Cal, and maintain that eligibility throughout their correctional stay, sometimes in a suspended status or limited aid code. As a result, WPC-LA benefits for the Justice-involved high risk population may focus on Medi-Cal eligible or enrolled beneficiaries, without duplicating available Medi-Cal covered services.

Flexible Housing Subsidy Pool (FHSP): As described in section 2.3, LAC-DHS will operate a FHSP that offers 1) tenancy support services, 2) move-in assistance, and 3) rental subsidies. These services are not currently available through the Medi-Cal program. The WPC-LA Budget only requests payment for the tenancy support services and move-in assistance, and does not request payment for the rental housing subsidies, consistent with STC 114 and the most recent federal guidance (June 26, 2015 CMCS Information Bulletin, Coverage of Housing-Related Activities and Services for Individuals with Disabilities). LAC-DHS currently intends to contract with a vendor for FHSP services, and will separately identify in its accounting payments for rental housing subsidies from payments for move-in assistance and tenancy support services for which WPC-LA funding is available.

Coordination with Drug Medi-Cal: The County is preparing to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) in the middle of 2017. The proposed DMC-ODS will offer more comprehensive support for individuals with substance use disorders; however, it does not provide assistance to help high-risk beneficiaries access and navigate services before formal enrollment into DMC-ODS. WPC-LA will offer this support for the target population prior to enrollment in DMC-ODS.

Services to Individuals in an Institute for Mental Diseases (IMD): As part of the Residential and Bridging Care Transition program, WPC-LA payments will support the transition of eligible Medi-Cal patients currently residing in inpatient psychiatric facilities and IMDs to community-based settings. As part of these transitions, the Residential and Bridging Care Transitions teams will perform services for patients before they are released from the IMD, as well as after, so they are integrated with the community. Services provided to patients in an IMD are generally not covered by the Medi-Cal program, but may be covered through the WPC Pilots under the Medi-Cal 2020 demonstration. Coverage of services prior to discharge from an IMD are a necessary component of the WPC-LA's strategies for managing transitions into the community and reducing length of stay within institutional settings. The discharge services provided through WPC-LA do not duplicate coverage otherwise available through Medi-Cal.

Care Support Services: As described in the toolkit, intensive care support and coordination activities are a core element of all components of the WPC-LA, and will be available to all WPC-LA clients. Under WPC-LA, care support and coordination will be provided through teams that include CHWs who will meet clients in their community, and who have a shared lived experience with the WPC-clients, with supervision by nurse care managers and licensed social workers. The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management ("TCM") benefit. Specifically, the team-based structure of WPC-LA's care support and coordination departs significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between WPC-LA team members and patients would not be eligible for reimbursement under TCM, as the workers either would not meet the education/experience requirements for TCM case workers or the team members would be in a supervisory role and would have few, if any, direct contact with clients. Moreover, the scope of care support and coordination activities available through WPC-LA is intended to be more robust than available through Medi-Cal TCM. WPC-LA teams will engage in activities such as peer support, trust-building, motivational supports, disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC-LA will also provide direct social and other services that would not be recognized as TCM, such as benefits advocacy or tenancy supports. For these reasons, we have concluded that the vast majority of WPC-LA activities will not duplicate services available through Medi-Cal TCM. However, in response to DHCS' concerns, we have applied a TCM budget adjustment to several of the programs to reduce our request for Whole Person Care funds. Documentation of the TCM adjustment has been provided to DHCS and is available upon request. Due to the complexity of separately identifying and accounting for individual encounters or activities that will occur through the WPC-LA programs, LAC does not anticipate claiming any WPC-LA activities under the TCM benefit, however, we reserve the right to make such claims up to the amount of the applied TCM budget adjustment. The same TCM adjustments approved as part of the WPC-LA budget would be applied with regard to the reporting of expenditures under the WPC-LA pilot, to the extent such reporting is required.

Non-Duplication within WPC-LA Components. WPC-LA will operate a component-specific enrollment practice that ensures that individuals are not enrolled into multiple components that have overlapping services. For example, individuals enrolled into the Re-entry program would not be enrolled into the HCSS service component until after their enrollment in the Re-entry program has terminated, even if they otherwise meet the applicable criteria, because both programs include a case management component. Similarly, individuals enrolled into the ISR component would not be enrolled into HCSS component. Individuals may be enrolled into multiple WPC-LA components, such as benefits advocacy and HCSS, when those components do not include overlapping services. For a description of the methodology for ensuring non-duplication, see Table 2.3b.

## 5.5 Funding Request – Budget Narrative

The Funding Request (Budget) for WPC-LA is attached to this submission as the WPC-LA Budget, which was completed based on the template provided by DHCS. The WPC-LA Budget identifies the payment amounts proposed for each budget category identified by DHCS for each program year, the discrete deliverables within each budget category for which payment is sought, and the dollar amounts associated with those deliverables.

As a supplement to the WPC-LA Budget, this Budget Narrative summarizes the activities included in each deliverable, the rationale for including those deliverables in the pilot, a description of the method for calculating the payment amount for each deliverable, and an explanation of how we reached the amounts associated with each deliverable. In determining the payment amounts associated with each deliverable, we have had to make assumptions about future costs, required staffing levels, and other programmatic matters. Also, as described in Section 5.4 above, these budget amounts reflect, as appropriate, a reduction based on a TCM adjustment factor. Additional back-up on these estimated costs and assumptions is available upon request.

As WPC-LA is implemented, actual expenses may be higher or lower than projected for specific line items in the attached justification tables and/or in the aggregate for a deliverable. However, payments for each deliverable will not exceed the amount identified for the deliverable in the approved WPC-LA budget detail, which may be modified from time to time in accordance with DHCS guidelines.

### Administrative Infrastructure

WPC-LA is budgeting between $28 and $33 million per year for administrative infrastructure. These amounts reflect approximately 12 to 13 percent of overall WPC-LA funding.

These levels of Administrative Infrastructure expenditures included in the WPC Budget are necessary for the successful operation of WPC-LA activities. Administrative infrastructure components have been grouped into four deliverables that each have an identified funding amount.

1. Program Governance and Leadership: WPC-LA will have a leadership team that will be responsible for the oversight of the Pilot. The leadership team will meet at least quarterly. Directorship positions over WPC-LA components affecting distinct target populations, such as homelessness and re-entry, will also be included in this category. Payments for this deliverable primarily reflect staffing costs of the leadership team and directorship positions and related administrative support.

2. IT Infrastructure: WPC-LA will develop specific IT infrastructure to successfully operate, monitor, and evaluate the program. Examples of planned IT infrastructure expenditures include:
   - Hardware purchases, including computers, cell phones, and tablets;
   - Software development that is not directly used in the provision of care, such as the development of a risk stratification tool specific to the WPC-LA population;
   - Enhancements necessary for the expanded use of telemedicine;
   - Support for data collection and data sharing tasks, including certain staff contract costs;
   - Ongoing IT maintenance, storage, and support.
   - Additional staffing and associated costs to manage and oversee the Round 2 expansion of WPC-LA.

Only expenditures targeted toward the WPC-LA or expenditures for which an appropriate percentage allocation was made have been included.

3. Program Development, Support, and Evaluation: Various administrative activities related to the development, support, and evaluation of WPC-LA will be performed. These activities include:
   - Staffing and service costs, including both employment and contract expenditures, such as for finance staff, legal services, or for staff working with contracts and grants;
   - Costs related to the operation of the regional coordinating centers;
   - Operation of a training and performance improvement institute for training and educating WPC-LA personnel;
   - Non-clinical office space, which is anticipated to be new space acquired through lease;
   - Reporting and evaluation functions
   - Costs related to WPC-LA performance improvement; and
   - Administrative staffing to manage and oversee the Round 2 expansion of WPC-LA, including increased training and performance improvement support infrastructure, senior leadership to manage mid-level managers, program managers for expanding programs, and contracting entities to ensure WPC-LA targets are met.

4. Outreach and Engagement: WPC-LA will conduct ongoing outreach and enrollment, including the development and operation of mobile street outreach teams that will engage homeless individuals and seek to connect them to appropriate services and benefits. Costs include staffing of appropriate personnel as well as costs of materials and other supplies.

Expenditures considered in determining the value of the administrative infrastructure deliverables do not duplicate expenditures included in other categories, including those deliverables in the delivery infrastructure category or service payments.

## Delivery Infrastructure

WPC-LA is budgeting $5 to $10 million per year for delivery infrastructure. These amounts will reflect approximately 3 percent of overall WPC-LA funding.

Delivery infrastructure payments are for the development and establishment of core program components that directly impact the ability to provide services or interventions. In some cases, delivery infrastructure components, including medical equipment and transportation costs, are built into the rates for specific services and are therefore not included in this category.

Delivery infrastructure components have been grouped into two deliverables that each have an identified funding amount.

**1.** Clinical Space and Facility Improvement: WPC-LA will secure new clinical space for the operation of specific WPC-LA activities, specifically recuperative care, sobering centers, and other clinical settings. We anticipate this will be new space secured through a lease. In estimating these costs, we looked at comparable buildings in the target geographic areas.

**2.** Clinical Software Tools: WPC-LA will develop new software needed for the delivery of services as part of WPC-LA. Examples of such software include a robust care management platform that WPC-LA staff will use at the point of engagement to confirm program eligibility, obtain consent for program participation and data sharing, and create ongoing care plan. In addition, WPC-LA

will develop a custom discharge plan within the Jail Electronic Health Record to facilitate coordination of care following release from jail, that will contain all information necessary (e.g. information on the client's WPC community re-entry team, providers and appointments, and medical, behavioral health, and a social service follow-up plans) for community-based providers and the client to transition safely to the community. This deliverable also includes the expansion of IT components to support the Round 2 expansion, and related IT consulting costs.

## Incentive Payments

WPC-LA also proposes an annual budget amount for incentive payments related to the achievement of specific operational deliverables that are critical to the success of WPC-LA. These incentive amounts fall within two categories: 1) incentive payments earned by the WPC-LA pilot through the timely achievement of significant project milestones, and 2) incentive payments made by County agencies to benefit community providers and other downstream (non-County) participating entities for undertaking WPC-LA activities and strategies.

1. Project Milestone Incentives

Project milestone incentive payments will be paid to the WPC-LA Pilot based on achievement of the incentive targets listed below. There are three project milestone incentives, related to timely implementation, physical infrastructure development, and IT/Quality Infrastructure development. The incentives are predominantly focused on Year 2 and Year 3, and are essential to help ensure that key process milestones in WPC implementation are met.

For each of the three incentives, achievement is measured based on performance of multiple activities/measures and calculated using a point system that reflects the value of the activities/measures. Payment of the full incentive will be available for meeting the incentive target identified below, as measured using the point system. Reduced payment is available for partial performance toward the incentive target, but no payment will be earned if the applicable points are less than a minimum threshold (generally 50% of the incentive target). The incentive payment amounts were established to reflect their value to advancing the effectiveness of the program component and the overall WPC-LA objectives. The specific measures and the applicable point system, and the amounts of the maximum payment for each incentive, are identified below. In addition, points earned for each measure may range from 0 to the amount listed in the tables below.

Project Milestone Incentives – Budget Amounts (aggregate of maximum Project Milestone Incentives)

| | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| Maximum Incentive Pool Payments | $34,250,000 | $16,500,000 | $1,750,000 | $0 |

a. Timely Implementation Incentive (Round 1). This incentive payment will be earned for achieving timely implementation of WPC-LA program components. Success in achieving timely implementation will be evaluated using a point system that reflects the relative achievement across the different WPC-LA components, described below. The amounts below will be earned for achieving 2,500 points in a given year, with partial payment available in proportion to that score, provided a minimum of 1,250 points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 2,500 points (minimum 1,250 points for partial payment) | $12,500,000 | $0 | $0 | $0 |

| Metrics | Goal | Points |
|---|---|---|
| Benefits Advocacy program started in a timely manner | July 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Justice involved High-Risk re-entry program started in a timely manner | July 1, 2017 | 800 points (Lose 20 points per week delayed) |
| Intensive service recipients program started in a timely manner | July 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Residential and Bridging Care program started in a timely manner | July 1, 2017 | 300 points (Lose 20 points per week delayed) |
| SUD-Engagement, Navigation, & Support program started in a timely manner | July 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Medically Complex Transitions of Care program started in a timely manner | July 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Office of Performance Improvement opened and operating in a timely fashion | July 1, 2017 | 150 points (Lose 10 points per week delayed) |
| Training Institute opened and operating in a timely matter | July 1, 2017 | 150 points (Lose 10 points per week delayed) |
| First WPC community networking meeting held by Area Health Officers in each Service Planning Area (SPA) | July 1, 2017 | 200 points (Lose 25 points per SPA not opened) |

b. Timely Implementation of Round 2 WPC-LA Expansion. This incentive payment will be earned for achieving timely implementation of the Round 2 expansion of WPC-LA. As with Round 1, success in achieving timely implementation will be evaluated using a point system that reflects the relative achievement across the different WPC-LA components, described below. The amounts below will be earned for achieving 1,400 points in Y2 and 350 points in Y3, with partial payment available in proportion to that score, provided a minimum of 700 and 175 points, respectively, are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| 1,400 points needed in PY2 and 350 points needed in PY3 (minimum 700 and 175 points needed for partial payment) | $7,000,000 | $1,750,000 | $0 | $0 |

| Metrics | Goal | Points |
|---|---|---|
| HCSS and TSS expansion started in a timely manner | November 1, 2017 | 150 points (Lose 10 points per week delayed) |
| Psychiatric Recuperative Care program started in a timely manner | November 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Juvenile Justice program started in a timely manner | November 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Kin Thru Peer program started in a timely manner | November 1, 2017 | 100 points (Lose 20 points per week delayed) |
| MAMA's perinatal high-risk program started in a timely manner | November 1, 2017 | 300 points (Lose 20 points per week delayed) |
| Medical Legal Partnership program started in a timely manner | November 1, 2017 | 100 points (Lose 20 points per week delayed) |
| Street teams added | 8 street teams each in PY2 & 3 | PY2: 200 points<br>PY3: 400 points<br>(Reduce by 50 points per team not deployed) |

c. Physical Infrastructure Incentive. This incentive payment will be earned for implementing critical physical infrastructure for WPC-LA program delivery. Success will be evaluated using a point system that reflects the relative weight of the applicable milestones, described below. The amounts below will be earned for achieving 1,400 points in PY2, 700 points in PY3, and 350 points in PY4 with partial payment available in proportion to that score, provided a minimum of 700 points are achieved in PY2, 350 in PY3,and 175 points in PY4.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 1,400 points in PY2, 700 points in PY3, and 350 points in PY4 (minimum 700, 350, and 175 for partial payment, respectively) | $7,000,000 | $3,500,000 | $1,750,000 | $0 |

| Metrics | Goal | Points |
|---|---|---|
| New medical recuperative care beds added | PY2&3 only<br>100 new beds each in PY2 & 3 | PY2&3<br>400 points each year<br>(Lose 4 points for every bed not opened) |
| New Sobering Center beds added | PY2&3 only | PY2&3<br>200 points each year |

| | | |
|---|---|---|
| | 50 new beds each in PY2 & 3 | (Lose 4 points for every bed not opened) |
| Regional Coordinating Centers (RCCs) opened and operating | PY2 only<br>8 RCCs | PY2 only - 800 points<br>(Lose 100 points for every RCC facility not opened) |
| New psychiatric recuperative care beds added (round 2) | PY2&3:<br>50 new beds<br>PY4:<br>100 new beds each year | PY2&3 - 200 points<br>(Lose 4 points for every bed not opened)<br>PY4 – 400 points<br>(Lose 4 points for every bed not opened) |

d. IT/Quality Infrastructure Incentive. This incentive payment will be earned for implementing critical physical infrastructure for WPC-LA program delivery. The foundational infrastructure developed in PY2 and PY3 for information systems, data integration and analytics approach, performance improvement framework, and approaches to addressing access and capacity issues in our existing delivery system will be critical to the success of WPC-LA, and will contribute to the sustainability of the programs beyond 2020. The dollar amounts associated with these activities is based on the value they wil have for WPC and for the Medi-Cal program. Success will be evaluated using the relative weight of the applicable milestones, described below. The amounts below will be earned for achieving 1,550 points in PY2 and 2,250 in PY3, with partial payment available in proportion to that score, provided a minimum of 775 or 1,125 points are achieved, respectively.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 1,550 points in PY2, and 2,250 points in PY3.<br>(minimum 775 and 1,125 points, respectively) | $7,750,000 | $11,250,000 | $0 | $0 |

| Metrics | Goal | Points |
|---|---|---|
| Care Management IT Platform (Beta version) launched in a timely manner | July 1, 2017 | PY2: 250 points<br>(Lose 10 points per week delayed) |
| Care Management IT Platform (Final version) launched in a timely manner | October 15, 2017 | PY2: 200 points<br>(Lose 20 points per week delayed) |
| Number of acute care facilities that start sending real-time Admission/Discharge/ Transfer | PY2 only<br>12 acute care facilities | PY2: 300 points<br>(Lose 50 points for every acute care facility short of goal) |

| | | |
|---|---|---|
| (ADT) feeds to the Care Management Platform | sending ADT feeds | |
| Develop a monthly whole person care quality dashboard | October 15, 2017 | PY2: 150 points (Lose 20 points per week delayed) |
| Develop and report on a client experience measure across all WPC programs | October 15, 2017 | PY2: 150 points (Lose 20 points per week delayed) |
| Care Management IT Platform (Beta version) launched for Round 2 in a timely manner | December 1, 2017 | PY2: 200 points (Lose 20 points per week delay) |
| Care Management IT Platform (Final version) launched for Round 2 in a timely manner | January 15, 2018 | PY3: 300 points (Lose 20 points per week delay) |
| WPC Referral Access Line & Call center launched in a timely manner | December 1, 2017 | PY2: 200 points (Lose 20 points per week delayed) |
| Community Resource Platform (CRP) launched | December 1, 2017 | PY2: 200 points (Lose 20 points per week delayed) |
| Community Governance Board established for CRP | February 1, 2018 | PY3: 200 points (Lose 10 points per week delayed) |
| CRP launched in Spanish Language | February 1, 2018 | PY3: 100 points (Lose 20 points per week delayed) |
| Create countywide roadmap for data integration | March 1, 2018 | PY3: 300 points (Lose 20 points per week delay) |
| LA County Health Information Exchange data participation agreement revised to accommodate WPC-LANES HIE use cases | December 1, 2017 | PY2: 100 points (Lose 20 points per week delayed) |
| Bi-directional interface built between LA County Health Information Exchange and CMP | March 1, 2018 | PY3: 300 points (Lose 20 points per week delayed) |
| LA County Health Information Exchange support program launched | February 1, 2018 | PY3: 150 points (Lose 20 points per week delayed) |

| | | |
|---|---|---|
| Create a unique identifier between County Agencies through the Countywide Master Data Management (CWMDM) Project | 6 County agencies | PY3: 300 points (Lose 50 points for every County agencies not linked through CWMDM) |
| Working with primary care practices, produce a report delineating strategies for expedited primary care access for WPC clients | February 1, 2018 | PY3: 150 points (Lose 20 points per week delayed) |
| Working with primary care practices, implement procedures to expedited primary care access for WPC clients | March 1, 2018 | PY3: 300 points (Lose 20 points per week delayed) |
| Working with specialty mental health partners, produce a report delineating strategies for expedited community mental health access for WPC clients | February 1, 2018 | PY3: 150 points (Lose 20 points per week delayed) |
| Working with specialty mental health partners, implement procedures for expedited community mental health access for WPC clients | March 1, 2018 | PY3: 300 points (Lose 20 points per week delayed) |

2. Downstream Provider Incentives

Over the course of WPC-LA, as part of the contracting and negotiating process with downstream providers, County agencies will provide financial incentives to downstream providers to reward the timely achievement of key WPC-LA goals. Downstream providers eligible for incentives will predominately be client service providers (e.g. HCSS and Re-entry contractors, transportations providers, primary care providers), but will also include other types of partners (e.g. vendors that create our care management IT platform and the LAC health information exchange, trainers, and medical-legal partnership vendors). We will clearly delineate expectations for downstream providers to receive an incentive payment during the contracting process; however, these expectations will vary by provider type.

The annual aggregate amount of incentive payments to downstream providers shall not exceed the amounts identified in the Aggregate Budget Table below. Incentive measures for downstream providers are outlined below, along with the expected range of the payments and the total amounts that will be expended for each category in Year 2. WPC-LA may make payments to downstream providers that do not meet the precise parameters described in the Incentive Measures Table as a result of negotiation

with providers or unanticipated needs. WPC-LA will be reimbursed based on its reported costs in making the incentive payments to downstream providers, up to the budgeted amounts.

Aggregate Budget Table

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Incentives Paid to Downstream Providers | $10,925,000 | $7,425,000 | $4,925,000 | $2,500,000 |

Incentive Measures for Downstream Providers

| Organization Type | Measures | Range of Incentive/ Organization | Minimum number of recipients (PY2) | Range of Total Incentive (PY2) |
|---|---|---|---|---|
| Homeless High-risk Provider Incentives<br>- We will select the most relevant measures from the following Homeless High-risk measure set for a total of $2.75m in maximum incentives for Year 2. Reduced payments will be made in Years 3 through 5, in line with the Budget outlined above. | | | | $2.75m |
| Homeless High-Risk Provider Incentives | Achieving organization's target client engagement for the year as specified in contract (HCSS, Recuperative Care, Sobering Center Providers) | $25-50K | 30 | $1.5m |
| | Accompanying >80% of WPC clients to a primary care appointment at least once annually (HCSS providers) | $25-50K | 20 | $1m |
| | Linking >50% of WPC clients to permanent housing within 3 months of admission to recuperative care (Recuperative Care Providers) | $75K | 3 | $225K |
| | Achieving >60% success rate on SSI/SSDI Advocacy applications (Benefits Advocacy) | $75K | 2 | $150K |
| | Performing a post-hospital discharge home visit within 3 business days of hospital discharge on >80% of discharged clients (HCSS providers) | $10-25K | 20 | $500K |
| | Performing a post-hospital discharge primary care visit within 1 month of hospital discharge on >80% of discharged clients (HCSS providers) | $10-25K | 20 | $500K |
| | Creating a comprehensive care plan on >80% of WPC clients within a month of enrollment | $25-50K | 20 | $1m |

| | | | | |
|---|---|---|---|---|
| Justice Involved High-risk Provider Incentives<br>- We will select the most relevant measures from the following Justice Involved High-risk measure set for a total of $3.5m in maximum incentives for Year 2. Reduced amounts will be paid out in Years 3 through 5, in line with the Budget outlined above. | | | | $3.5m |
| Justice-involved High-risk Provider Incentives | Achieving organization's target client engagement for the year (as specified in contract) | $10-50K | 20 | $1m |
| | Accompanying >80% of WPC clients to a primary care appointment at least once annually | $10-25K | 20 | $500K |
| | >80% of clients released from LA County jail or California state prisons who are engaged within 5 days of release/return to LA County | $10-25K | 20 | $500K |
| | >50% of clients released from LA County jail or California state prisons have a primary care appointment within 1 months of release | $10-25K | 20 | $500K |
| | Performing a post-hospital discharge home visit within 3 business days of hospital discharge on >80% of discharged clients | $10-25K | 20 | $500K |
| | Performing a post-hospital discharge primary care visit within 1 month of hospital discharge on >80% of discharged clients | $10-25K | 20 | $500K |
| | Creating a comprehensive care plan on >80% of WPC clients within a month of enrollment | $10-50K | 20 | $1m |
| | Hiring and deploying their re-entry care coordination teams in order to achieve their target client engagement by June 1, 2017 | $5-50K | 20 | $1m |
| IT Vendor Incentives<br>We will select the most relevant measures from the following IT Vendor incentive measure set for a total of $675K in maximum incentives for PY2, and $425K in PY3-5. | | | | $675K (PY2)<br>$425K (PY3-5) |
| CMP IT Vendor | Bringing online full version of WPC client tracking tool by January 1, 2017 | $250K | 1 | $250K |
| | Bringing online full beta version of the Care Management platform by March 1, 2017 | $250K | 1 | $250K |
| | Bringing online final version of the Care Management platform by July 1, 2017 | $250K | 1 | $250K |
| LANES Discounts | Provide LANES annual subscription fee discounts to hospitals connecting to LANES by December 31st of each year. | $25-50K | 10 | $350K |

| | | | | |
|---|---|---|---|---|
| | Provide LANES annual subscription fee discounts to community clinics connecting to LANES December 31st of each year. | $5-25K | 10 | $75K |
| Clinical Provider Access Incentive<br>- We will select the most relevant measures from the following Clinical Provider incentive measures for a total of $3.5m in maximum incentives for Year 2. Reduced amounts will be paid out in Year 3 and Year 4, in line with the Budget outlined above. | | | | $3.5m |
| Primary Care Providers | Achieving 2-week post-discharge follow-up on >50% of WPC clients referred to their clinic | $50-100K | 20 | $2m |
| FSP Providers | Achieving 4-week access for >50% of WPC clients referred to their FSP program | $50-100K | 20 | $2m |
| SUD Providers | Achieving 4-week access for >50% of WPC clients referred to their SUD program | $50-100K | 20 | $2m |
| Medical-Legal Partnership Provider Incentives (Round 2)<br>WPC-LA will make up to $100,000 in payments to County-approved legal service vendors in PY2, $600,000 in PY3, and $500,000 in PY4&5 to increase the vendors' capacity to assist WPC-LA clients through medical-legal partnerships | | | | $100K in PY2, $600K in PY3, $500K in PY4 & 5 |
| Legal Service Vendors | Providing end-to-end legal services for MLP cases referred from or approved by WPC-LA staff as having a connection to the client's medical care.<br><br>Based on overall complexity of the legal services provided, WPC-LA will provide the following incentive to each approved MLP provider for services delivered up to the maximum number of unique clients listed below:<br>1) low complexity - $100-500 per case for up to 6,000 cases/year maximum<br>2) medium complexity - $500-$1,000 per case for up to 1200 cases/year maximum<br>3) high complexity - $1,000 -$10,000 per case for up to 600 cases/year maximum<br><br>Threshold targets for the number of cases will be developed through the County approval process, and will be included in MLP partner contracts. WPC-LA will pay incentives on a pro rata basis to organizations. | $25-200K, based on size of threshold target | 5 | PY 2: $100K<br>PY3: $600K<br>PY4-PY5: $500K |

Discrete (Non-Bundled) Services

The following WPC-LA services will be reimbursed on a non-bundled, per-encounter basis:

1. Sobering Center Encounters: WPC-LA will earn payments on a per encounter basis for each encounter with an eligible individual that results in the use of an occupied bed at the sobering center. WPC-LA payments will be determined by multiplying the number of such encounters by the approved rate, up to the caps set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Encounters | 23,269 | 32,850 | 32,850 | 32,850 |
| Rate/Encounter | $260.70 | $263.03 | $271.31 | $279.45 |
| Budget | $6,066,142 | $8,640,432 | $8,912,415 | $9,179,788 |

Under WPC-LA, LAC DHS will contract with experienced vendors for the operation of 24-7 community-based sobering center sites to provide an alternative destination for individuals that present to law enforcement, fire departments, and other first responders with severe intoxication. Vendors contracted with LAC DHS will provide onsite services including medical triage, point of care lab testing, client beds, oral rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, homeless care support services, and linkage to health, behavioral health, and substance use disorder services. It is expected that the availability of the sobering centers will directly reduce emergency department visits, increase EMT time in the field, and reduce admissions to jails.

The attached Sobering Center Budget Justification Table provides support for the payment rates. The proposed pre-determined per encounter rates were developed using certain assumptions about the relative turnover and case load for the sobering centers. These assumptions were based on benchmarks from currently open sobering centers in other jurisdictions. In setting the per encounter rates, we have projected that sobering centers will have an average of one WPC-LA client per bed per day; average encounters are less than 24 hours. In incorporating the contract costs into the rates, we have included 90% of the estimated costs.

The estimated costs of vendor contracts have been derived from preliminary information from potential vendors, projection of the availability capacity of the sobering centers, and the costs of existing sobering centers in jurisdictions with similar costs. WPC-LA currently plans to increase the number of beds available in sobering centers over the course of the pilot. During Year 2, we estimate there will be an average of 71 beds; Years 3 through 5 there will be 100 beds. The costs of securing or improving the space for the sobering centers is included as a delivery system infrastructure cost and is not incorporated into the service rates. The per encounter rates reflect changes related to the expansion of beds and a 3 percent cost of living increase.

## Bundled Services

Target Population 1: Homeless High-Risk Service Deliverables

As described in Section 3.1, the WPC-LA will offer multiple packages of services and interventions for homeless WPC-LA clients. Four of these packages will be paid using either a pmpm, per individual, or per encounter rate that bundles multiple services available through that program component.

1. Benefits Advocacy: WPC-LA benefits advocacy services will be paid the rate set forth below for each eligible individual engaged by the benefit advocacy service team. WPC-LA payments for benefit advocacy services will be determined by multiplying the number of individuals engaged by the

approved rate, up to the budget amounts set forth below. Benefits advocacy services may be ongoing over the course of many months; WPC-LA will only be paid once per enrollee.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Enrollments | 10,000 | 10,000 | 10,000 | 10,000 |
| Rate/Enrollment | $764.02 | $786.94 | $810.54 | $834.86 |
| Budget | $7,640,160 | $7,869,365 | $8,105,445 | $8,348,609 |

Services included in this bundle include comprehensive benefits advocacy services, including advocacy for SSI or SSDI benefits. Benefits advocacy assists homeless individuals to move to stable housing. We project that approximately 50% of individuals engaged and enrolled by the homeless benefit advocacy teams will submit applications for benefits. We aim to have 80% of applications submitted result in approval of benefits. Benefits advocacy specialists will manage a caseload of up to 100 clients.

The attached Benefits Advocacy Budget Justification Table provides support for the payment rates. Expenditures included in the justification consist of contract costs with community-based service providers. Descriptions of the contracted services and the role and projected makeup of the administrative support team are included.

2. Homeless Care Support Services (HCSS): HCSS services will be paid on a per member per month basis at the rates set forth below for eligible individuals who are housed and in need of support services to remain stably housed. WPC-LA payments for HCSS will be determined by multiplying the number of member months by the approved rate, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member months | 52,200 | 74,400 | 103,200 | 119,700 |
| PMPM | $514.15 | $434.74 | $406.64 | $380.17 |
| Budget | $26,838,745 | $32,344,710 | $41,965,042 | $45,506,155 |

HCSS services are comprehensive wrap around services provided to homeless clients, including: outreach and engagement; ongoing monitoring and follow up; linkage to health, mental health, and substance use disorder services; benefits establishment; assistance with life skills, job skills, and educational and vocational opportunities; crisis intervention; and other services necessary to assist clients in regaining stability and health. HCSS services do not include the provision of room and board.

To determine the number of member months, we projected an enrollment based on an anticipated ambitious expansion over the life of WPC-LA. Enrollment levels reflect estimates of 3,800 clients in January 2017, with monthly increases that ramp up over PY2 and add an estimated 200 new clients per month beginning in January 2018. By December 2020, it is estimated that we will be serving 10,000 clients. The case load for HCSS care managers will vary from 20 clients per care manager (for high acuity and bridge clients) to 40 clients per care manager (low acuity).

The attached Homeless Care Support Service Budget Justification Table provides support for the payment rates. Expenditures included in this justification consist of contract costs with vendors and reflect estimates based on information from pre-qualified contractors. The annual rates reflect projected adjustments to the acuity of the case load over time, which are anticipated to be higher during Year 2 than in later program years. Contract payments for HCSS services are projected to be paid

at an interim housing rate when provided to enrollees in temporary housing, and a low or high rate when provided to an enrollee in permanent housing based on the acuity of the client. The determination of a client's acuity level will be made consistent with written standards and criteria. To determine the estimated utilization, we modeled that the first two months of a newly housed individual will be at the interim rate, the next 12 months at the high acuity rate, and any subsequent months at the low acuity rates (for 2018 the high to low ratio would be 70/30, for 2019 it is 60/40 and in 2020 50/50). These estimates are based on projections consistent with historical experience, which reflect an average time of 2 months to get into permanent housing. The payment rates also reflect a reduction due to a TCM adjustment of 3%.

3. Tenancy Support Services: Tenancy support services will be paid a distinct pmpm for each individual determined and enrolled as part of the HCSS component. Individuals enrolled in the HCSS component are eligible for tenancy support services based on an assessment of their needs. The member months will be the same as the member months determined for the HCSS. WPC-LA payments will be determined by multiplying the number of member months by the approved rate, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member months | 52,200 | 74,400 | 103,200 | 119,700 |
| PMPM | $161.66 | $142.35 | $132.00 | $124.37 |
| Budget | $8,438,540 | $10,590,758 | $13,622,383 | $14,887,388 |

Each member of HCSS is eligible to receive services from the tenancy support services, and will be provided with such services based on an assessment of client needs. Services provided through the tenancy support services bundle include: 1) initial move-in assistance costs (including payment of security deposits, furniture, household goods, minor unit modifications, and other costs related to accommodating clients with mobility challenges and disabilities); and 2) housing location services to assist clients identifying safe and affordable housing, crisis intervention services, health and safety visits, unit habitability inspections, coordination between the landlord and case management provider to address unit or tenancy issues, and other housing retention services. WPC-LA payments for tenancy support services do not reflect any costs related to rental subsidies. Housing coordinators will manage a caseload of up to 100 clients.

The attached Tenancy Support Services Budget Justification Table provides support for the payment rates. Tenancy support services will be provided primarily through contracts with vendors; contract costs have been projected using information learned through the pre-qualification of vendors and an estimate of utilization. To determine the rates, we divided the projected contract costs for individuals receiving tenancy support services (not inclusive of any costs related to rental subsidies) by projections of HCSS enrollment. LAC will maintain separate budget line items for payments to tenancy support service vendors for rental subsidies vs. payments for tenancy support services and move-in costs.

4. Recuperative Care Services: Recuperative care services will be paid on a per member per month basis for individuals in a recuperative care setting at the rates set forth below. Separate rates will be paid for individuals following a discharge from a psychiatric facility. To determine the number of member months a pro rata adjustment will be applied to account for the number of days in the recuperative care setting during the first and last month, with a maximum stay of 90 days. WPC-LA payments will be determined by multiplying the number of member months by the approved rate, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Member months (recup) | 2,700 | 3,780 | 3,780 | 3,780 |
| PMPM (recup) | $5,909.99 | $5,972.68 | $6,061.88 | $6,153.76 |
| | | | | |
| Member months (psych recup) | 135 | 945 | 1,620 | 2,160 |
| PMPM (psych recup) | $10,940.45 | $9,318.45 | $9,639.89 | $9,540.21 |
| Budget | $17,433,941 | $31,382,674 | $ $38,530,537 | $43,868,074 |

Services provided in this bundle include short-term residential care for homeless individuals who are recovering from an acute illness or injury and whose condition would be exacerbated by living on the streets, a shelter, or other unsuitable places. General oversight of medical conditions will also be provided, e.g., monitoring of vital signs, wound care, medication monitoring, etc. (just like they can occur at a patient's home for patients with housing). Other services will include assistance with activities of daily living (bathing, dressing, grooming, wheel chair transfers, etc.), but only when the activities are not covered through the In-Home Supportive Services benefit (IHSS); development and monitoring of a comprehensive homeless care support services plan; linkage to health, mental health, and substance use disorder services; benefits establishment (distinct from the SSI services provided through a separate deliverable); groups and social activities; transportation; facility operations; and coordination with permanent housing providers to support the transition of clients to permanent housing. Starting in July 2017, WPC-LA will also provide recuperative care services to individuals following a discharge from a psychiatric ward. In addition to the services described above, psych recuperative care services will include services and supports that are tailored to individuals following an acute psychiatric episode. Enrollment in the recuperative care component is limited by available beds. Over the course of WPC-LA, we estimate that we will add new beds to increase to over 700 available slots, including 200 psychiatric beds. We project the average stay in a recuperative care setting will be between 10 to 12 weeks, and have estimated 90% occupancy.

The attached Recuperative Care Bundle Budget Justification Table provides support for the payment rates. Expenditures for medical recuperative care services included in the justification include staffing costs for a clinical care team and an administrative team, as well as contract costs for homeless service providers experienced operating recuperative care settings. Projected staffing and contract expenditures are based on experience providing services at one location. Descriptions of the responsibilities of the clinical care team and the administrative team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. A cost of living adjustment of 3% was applied for years 3 through 5.

Expenditures for psychiatric recuperative care services are included in the attached Psychiatric Recuperative Care Bundle Budget Justification Table. These expenditures mirror those for medical recuperative care services, but reflect a different case team with a smaller caseload, and the additional of psychiatric program management costs including staff analysts and personnel to manage security and safety issues unique to this population. In addition, psychiatric recuperative costs reflect costs directly associated with the enrollment and placement of individuals leaving a psychiatric ward into a recuperative care setting. As a result of this placement, the hospitals releasing the individuals will lose the ability to bill the days prior to discharge as an administrative day; the average costs associated with

lost administrative days are included as a psych recuperative care placement fee. Descriptions of the responsibilities of the clinical care team, administrative team, and psychiatric program management team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. A cost of living adjustment of 3% was applied for years 3 through 5.

Target Population 2: Justice-involved High Risk Service Deliverables

Services provided to the justice-involved high-risk population are essential components of WPC-LA. Currently, most sick inmate-patients exit jails, prisons, and juvenile detention facilities without adequate reintegration support. This leads to inappropriate and avoidable health care utilization, deterioration of their health conditions while in the community and recidivism. WPC-LA will make services available to help prepare the sickest inmates for release into the community and then also support them for a period of months following re-entry to ensure a stable transition to their communities. These services include interventions to ensure adequate preparation and follow-up related to the re-entry.

Services that will be available to re-entry clients will include: SSI advocacy; transportation; case management support; service coordination across different health and social services and connections to new services; benefits establishment; coordination of medical/health records across different disciplines; family engagement and support services; education and employment supports; 24/7 crisis support; and a specific case manager to accompany participants when arranging and accessing social services and clinical services. Re-entry clients will receive discharge planning visits; engagement in in-custody substance use disorder services prior to re-entry with warm handoff to community based Drug Medi-Cal services; and discharge medications.

Starting July 1, 2017, WPC-LA payments for services and interventions provided to justice-involved high-risk populations will be paid through PMPMs for four distinct populations:

1) The Round 1 program, which targeted adult members of the target population for the first three months after they are released from jail or prison (Adult Jail Referral);

2) A new (Round 2) expansion that includes up to 200 slots for individuals who are referred to the program from community sources, after having been released from jail within the previous month. (Adult Community Referral). Individuals will remain in this component of the program for three months.

3) As part of the Round 2 expansion, WPC-LA is also extending the length of the Re-entry benefit for qualifying members of either population 1 or 2 above for a period of an additional six months. (Adult extended care). Individuals will qualify for these extensions if they are identified as needing continuing interventions. Identified individuals would be moved into this program after their initial three-month period ends. It is estimated that 25% of the adults in population 1 or 2 would qualify for these extended services. Services during this extended period would be comparable to the services and intensity of the Adult Jail Referral population, and would receive the same PMPM.

4) A new (Round 2) expansion that includes up to 100 slots for juveniles leaving the County justice system. (Juvenile Aftercare). Most individuals in this population will remain in the Justice Re-entry program for a period of six months, however approximately 25% of the population will receive extended care services for an additional six months; these additional services would continue to be paid at the juvenile PMPM.

In addition to the PMPMs for these 4 populations or time periods, WPC-LA will receive a one time per enrollee payment for each individual enrolled in the Re-Entry program (from any of the above populations) who was previously involved in the County justice system. This enrollment payment will be paid in recognition of the value of an effective transition directly into the program for individuals leaving incarceration.

The bundled rates for justice-involved populations are based on estimated costs of performing or arranging for the services. In developing these rates, we have not built in any savings or value-related adjustments due to potential reductions in the expected emergency department utilization or improvements in patient experience of care through the operation of the Re-entry program.

1. Justice-involved High Risk Re-Entry: Re-entry services for the justice-involved high risk population will be paid on a per member per month basis at the pmpm rates set forth below. Individuals will be enrolled in the Re-entry program into one of the 4 different populations identified above. Enrollment will start on the date of release (except for the Community Referrals program, which will begin on the date of the transition into that program), and continue on average for the time periods identified above. PMPMs for different program components will not be claimed for the same beneficiary for the same month. In addition, services for certain individuals immediately transitioning from a county correctional facility will also be reimbursed through a supplemental enhanced care coordination rate that is paid on a per eligible enrollee basis. WPC-LA payments for re-entry services will be determined by multiplying the number of member months by the applicable approved rate, and adding the supplemental enhanced care coordination rate multiplied by the number of eligible enrollees, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| PMPM payments | | | | |
| Adult Jail Referral Member Months | 32,250 | 45,000 | 45,000 | 45,000 |
| Adult Jail Referral PMPM | $427.56 | $421.67 | $398.46 | $408.96 |
| Adult Community Referral Member Months | 3,000 | 7,200 | 7,200 | 6,000 |
| Adult Community Referrals PMPM | $857.70 | $836.28 | $789.65 | $820.73 |
| Adult Continued Services Member Months | 6,863 | 25,950 | 26,100 | 26,100 |

| | | | | |
|---|---|---|---|---|
| Adult Continued Services PMPM | $427.56 | $421.67 | $398.46 | $408.96 |
| Juvenile Member Months | 2,100 | 8,625 | 9,000 | 8,400 |
| Juvenile PMPM | $881.94 | $828.26 | $779.65 | $803.07 |
| Per Enrollment Payments | | | | |
| Qualified Enrollments | 12,600 | 16,200 | 16,200 | 16,200 |
| Enhanced Enrollment Payment | $1,458.52 | $1,594.32 | $1,585.28 | $1,628.63 |
| Total Budget | | | | |
| Re-entry Program Budget | $39,525,677 | $68,910,583 | $66,714,383 | $ $67,130,832 |

Member months for the Adult Jail Referral (Round 1) population were based on an estimate of 3,750 enrollees per month once the program is fully implemented; estimates for Year 2 include a phase-in as individuals are enrolled. We project that each month, 1,250 individuals will enroll in the re-entry program (except in the first three months of the program in PY2 when 1,500 participants will be targeted) each month. The enrollment levels reflect an anticipated start of April 2017. Community Health Workers for the Adult Jail Referral (Round 1) population are estimated to hold a caseload of 30 clients.

Member months for the other populations were based upon a July 1, 2017 start date. For the Community Referrals program, the program will target 400 enrollments each month. For the Juvenile Re-entry program, the program will target 100 enrollments each month. We estimated that approximately 25% of the adults in the Re-entry program will be identified as high-risk and moved into the Continued Services program after their first three months are complete.

The attached Re-Entry Budget Justification Tables provide support for each of the pmpm rates. Costs included in the justification of the pmpm rates are comprised primarily of staffing costs, including the operation of a community/case worker team, clinical care team, administrative support team, as well as some supply costs. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. Supply costs include costs related to the provision of enhanced care support supplements, transportation costs for the community/case worker team, and other office supplies. A cost of living adjustment of 3% was applied for years 3 through 5. The payment rates reflect a reduction due to a TCM adjustment of 10% of the community/case worker team during years 4 and 5.

Rates for the Community Referral Re-entry population are higher than for the initial (round 1) population because we expect increased acuity and coordination complexity for these clients due to the

fact that they did not receive prior care planning while incarcerated. In comparison, to CHWs who receive a hand-off from the County Jail, CHWs receive community referrals must begin the process from the beginning – engaging the client, identifying their needs, creating a care plan, and accompanying the client to help address their needs. This increased work required to address this complexity requires lower caseloads. As a result, the community/case worker team and clinical care team will have smaller caseloads to deal with the greater complexity of the cases.

Costs for the Juvenile Re-entry population will also reflect a lower case load than for adult (round 1) populations, as a result of the increased need to work with family members and guardians and address family situations. This population also has a high prevalence of foster system involvement and deal with many other issues associated with juvenile populations.

For Continued Services recipients, the pmpm is the same as for the initial (round 1) populations. While these individuals are expected to be high-risk, it is not expected that the longer intervention during the 4th through 9th month will necessarily require more intensive case management than they were receiving in the first three months of their participation in the Re-entry program.

In addition to the pmpm payments, a one-time enhanced care coordination payment will be paid for each qualifying enrollment into the Re-entry population. This enhanced care coordination payment is not available for individuals in the community referral Re-entry population, but may be available for Juvenile Re-entry population members or adult members of the Adult Jail Referral (Round 1) populations. Costs included in the enhanced care coordination (per enrollment) payments are comprised primarily of staffing costs, including the operation of a community/case worker team, custody/sheriff team, clinical care team, pharmacy team, and administrative support team that will assist the client in preparation for and during the transition into the community, as well as some services and supply costs. Descriptions of the responsibilities of each team, and their projected makeup, are included in the attached table. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. Supply costs include costs related to the provision of enhanced care support supplements, transportation costs for the community/case worker team, and other office supplies. The payment rates reflect a reduction due to a TCM adjustment of 10% of the community/case worker team during years 4 and 5. A cost of living adjustment of 3% was applied for years 3 through 5.

Target Population 3: Mental Health High-Risk Service Deliverables

Individuals with serious mental illness (SMI) who lack wrap around services and supports frequently languish in institutional settings. The WPC-LA will offer three discrete service packages to help targeted individuals with SMI transition to less restrictive community settings, including facilitating the development of care plans that incorporate clinical, social, and navigational services to enable and support services required to remain safe and stable in the community.

1. Intensive Service Recipient (ISR) Services: WPC-LA ISR services will be paid on a per member per month basis at the rates set forth below. To determine WPC-LA payments for ISR services the number of member months will be multiplied by the approved rate, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member Months | 2,160 | 3,360 | 3,840 | 3,840 |

| | | | | |
|---|---|---|---|---|
| PMPM | $1,030.31 | $1,114.12 | $1,074.60 | $1,102.83 |
| Budget | $2,225,470 | $3,743,433 | $4,216,483 | $4,234,867 |

WPC-LA clients who are Intensive Service Recipients due to diagnosis of SMI and co-occurring substance use disorders, as well as frequent admissions to psychiatric inpatient facilities will receive the following services: in-hospital and in-home visits with a care coordination team, planning a daily program following release from institution, medication adherence supports, assistance in arranging support services like transportation, housing and food. A primary goal of these ISR services is to establish effective connections to continuity mental health and other care providers as identified in each patient's care plan. Once patients are established with a Full Services Partnership provider and a continuum of appropriate care providers, the patient will be transitioned out of and disenrolled from the ISR program.

Member months for the ISR were estimated based on projections of 240 people served each month during Year 2 (with some ramp up as the program starts), and increasing to 320 people each month by Year 5. Individuals are projected to remain in the program for three months. The increases reflect additional case load taken on by ISR teams over time, and to reflect efficiencies learned over the course of the pilot.

The attached ISR Budget Justification Table provides support for the payment rates. We project that the average length of time an enrollee will receive ISR services is three months. Costs included in this justification include staffing costs for a psychiatric social worker/case worker team that includes supervising psychiatric social workers, multiple psychiatric social workers and case workers, and related assistant and clerical support, as well as services, supplies and overhead. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. The decrease in the pmpm reflects that the teams will take on additional case load as the program continues. The payment rates reflect a reduction due to a TCM adjustment of 9.4% for the psychiatric social worker/case worker team.

2. Residential and Bridging Care Transitions: Residential and Bridging Care Transition services will be paid on a per member per month basis at the rates set forth below. In addition, an enhanced enrollment fee will be paid for each eligible enrollee transitioning out of an institution for mental diseases ("IMD"). WPC-LA payments for Residential and Bridging Care Transition services will be paid by multiplying the number of member months by the approved rate, plus the enhanced enrollment fee times the number of enrollees transitioning from an IMD, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member Months | 1,275 | 1,800 | 1,800 | 1,800 |
| PMPM | $2,139.52 | $2,076.70 | $2,134.43 | $2,193.88 |
| | | | | |
| Qualified Enrollments | 135 | 180 | 180 | 180 |
| Enhanced Enrollment Payment | $3,044.14 | $3,124.02 | $3,206.31 | $3,291.06 |
| Budget | $3,138,845 | $4,300,383 | $4,419,101 | $4,541,377 |

Residential and Bridging Care Transition services help transition clients from institutional to community settings, thereby allowing them to live in a less restrictive setting (consistent with the mission articulated in Olmstead) and freeing up institutional beds for other clients. These services include: identification of individuals eligible for transition; development of after care plans that cover a broad range of needs; discharge planning coordination linkage to community-based resources; benefit establishment, including advocacy and identification of barriers to establishment; peer support and family involvement; identification of housing opportunities and resources, including help with move-in; assistance with community integration, including skills development and coaching.

The PMPMs for each year reflect an estimated case load of 150 clients per month in Years 3 through 5. These projections reflect the limited availability of placements in the community. We project that the average length of time an enrollee will receive RBC services is two months. The reduced member months in Year 2 reflect an anticipated start date of April 2017.

The attached RBC Budget Justification Table provides support for the payment rates. Costs included in this justification include staffing costs for a psychiatric social worker/case worker team that includes multiple psychiatric social workers and case workers, an administrative support team, and services, supplies and overhead. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. The payment rates reflect a reduction due to a TCM adjustment of 18% for the psychiatric social worker/medical case worker team.

3. Kin-to-Peer (KTP) Program: KTP services will be paid on a per member per month basis at the rates set forth below. WPC-LA payments for KTP services will be determined by multiplying the number of member months by the approved rate, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member Months | 840 | 4,560 | 4,800 | 4,800 |
| PMPM | $1,246.17 | $1,240.20 | $1,242.32 | $1,271.36 |
| Budget | $1,046,783 | $5,655,312 | $5,963,136 | $6,102,528 |

KTP services will be provided by trained, certified peers providing a sustained kin function, including working collaboratively with clients in a family-like manner. The key goals of these services are to establish a trusting "surrogate family" or enduring relationship between the peer and the client, and to support clients to establish and maintain connectedness to services, supports and the community through this social support. WPC-LA will target enrollment of 40 new clients per month in the KTP program beginning in July 2017; the estimated time of involvement in the program is 12 months.

The attached KTP Budget Justification Table provides support for the payment rates. Costs included in this justification include staffing costs for a social support team that includes community workers as well as an administrative support team that includes mental health clinical program managers and other administrative support, as well as costs for services and support. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by the estimated workload, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. Cost estimates used to build the payment rates for the PMPM program reflect assumptions about staffing models and supply costs that equal, over the course of the program, the projected cost of the program. However, costs for individual years may be higher or lower

due to the expected rapid ramp up of the program in the early years and economies of scale achieved in the later years.

Target Population 4: SUD Engagement, Navigation, and Support (SUD-ENS) Service Deliverables

California counties are preparing to implement a new, more comprehensive Drug Medi-Cal program. LAC leaders hope that the program will launch in Los Angeles County during the middle of 2017. Although the program is designed to be much stronger than it was the past, access and navigation before formal enrollment into a Drug Medi-Cal program is not supported. WPC-LA will provide engagement, navigation and other support services for Medi-Cal beneficiaries with serious SUD to improve the likelihood that the client will become engaged and enrolled into the Drug Medi-Cal program, and so that services covered by Medicaid can benefit the patient.

SUD-ENS services include: services navigation support; housing access and support; SSI advocacy; transportation; connection to needed Drug Medi-Cal services; care coordination across different health and social services; connections to new services; 24/7 crisis support; benefits establishment; connection to homelessness pilot project services, as needed (such as intensive case management); child care, as needed; connection to education and employment services; family engagement and support.

1. SUD-ENS Services: SUD-ENS will be paid on a per member per month basis at the rates set forth below. WPC-LA payments for SUD-ENS will be determined by multiplying the number of member months by the approved rate, up to the budget amounts set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member Months | 5,508 | 7,776 | 7,776 | 7,776 |
| PMPM | $615.68 | $589.15 | $562.69 | $576.54 |
| Budget | $3,391,169 | $4,581,215 | $4,375,473 | $4,483,200 |

Enrollment in the SUD-ENS will be limited to 720 slots, with individuals expected to remain in the program an average of 2 months prior to transitioning to Drug Medi-Cal. We project a 90% occupancy rate for the available slots. The program is proposed to begin in April 2017 with up to 360 enrollees during the first month. CHW care managers are expected to carry a caseload of 30 clients.

The attached Substance Use Disorder – ENS Budget Justification Table provides support for the payment rates. Costs included in this justification include staffing costs, including the operation of a community/case worker team and the oversight of a medical director, as well as some services and supplies, staffing costs will be paid through either contract or employment relationships. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. Services and supply costs include the provision of enhanced care support supplement, transportation for the community/case worker team, and miscellaneous office supplies and fees. The payment rates reflect a reduction due to a TCM adjustment of 13.3% for the community/case worker team for years 4 and 5.

Target Population 5: Medically High-Risk: Transitions of Care Service Deliverables

WPC-LA will offer transitions of care interventions for a high-risk subset of individuals who meet certain eligibility factors. These are the highest cost individuals due to their recurrent medical hospital

admissions. An evidence-based hospital-to-home care transition approach will be used to support patients as they leave the hospital to support engagement with their primary care team, in conjunction with other services and support to address their ongoing needs and reduce unnecessary readmissions.

Transition of care services available through WPC-LA include: pre-discharge planning; post-discharge home visit; accompaniment to first primary care visit post-discharge; medication review; patient need assessments and linkage to services including transportation, housing, food, durable medical equipment and home health services; and ongoing communication with the primary care team.

1. Medically High-Risk: Transitions of Care services will be paid on a per member per month basis at the rates set forth below. Enrollment will begin with the date of discharge. WPC-LA payments for transitions of care services will be paid by multiplying the number of member months by the approved rate, up to the caps set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member Months | 2,295 | 3,240 | 3,240 | 3,240 |
| PMPM | $500.68 | $486.48 | $440.82 | $452.24 |
| Budget | $1,149,065 | $1,576,187 | $1,428,255 | $1,465,250 |

Individuals will be enrolled into the Medically High-Risk: Transitions of Care from hospitals beginning April 2017. We project that enrollment will be limited to 300 slots, with a 90% occupancy rate. The average length of time an individual will receive the transitions of care services is estimated to be one month. CHW care managers are expected to carry a caseload of 25 clients.

The attached Hospitalized Medically High-Risk: Transitions of Care Justification Table provides support for the payment rates. Costs included in this justification include staffing costs, including the operation of a community/case worker team and administrative team, as well as fees, supplies, and other costs. Staffing costs will be through either contract or employment relationships. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. Other costs include the provision of enhanced care support supplements, transportation for the community/case worker team, and other office supplies and fees. The payment rates reflect a reduction due to a TCM adjustment of 13.3% for the community/case worker team for years 4 and 5.

Target Population 6: High-Risk Pregnant Women

MAMA's Neighborhood Program will provide engagement, navigation, and other support services for pregnant Medi-Cal beneficiaries with high-risk psychosocial need to compliment Medi-Cal clinical services. These services can be expected to reduce complications and expenditures associated with the most vulnerable Medi-Cal maternity cases.

1. MAMA's neighborhood services will be paid on a per member per month basis at the rates set forth below. WPC-LA payments for MAMA's will be determined by multiplying the number of member months by the approved rate, up to the budget amount set forth below.

| | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|
| Member Months | 1,512 | 9,288 | 10,368 | 10,368 |

| | | | | |
|---|---|---|---|---|
| PMPM | $780.74 | $777.08 | $748.19 | $766.01 |
| Budget | $1,180,478 | $7,217,524 | $7,757,248 | $7,941,940 |

Services available through the MAMAs include:

- Administration of an initial comprehensive psychosocial intake risk assessment,
- Generation of a global risk score to frame intensity, frequency and duration of support services;
- An individualized care plan with readiness assessment;
- Navigation support to Neighborhood partner CBOs;
- Prenatal health education and resiliency building classes;
- Transportation and child care vouchers;
- Patient participation vouchers;
- Care coordination across public social services for pregnant women;
- Warm line crisis support;
- Benefits navigation;
- Home visitation;
- Risk appropriate referral plan and liaising to social, legal and education support services (housing, substance use, mental health, childcare, family engagement and parenting, employment and training support, domestic violence support, etc.)

Enrollment in MAMA's will be graduated as the program builds by referrals, with individuals expected to remain in the program an average of 18 months prior to transitioning out. We project a 90% active panel for the MCT over the duration of the pilot. The program is proposed to begin in July 2017. At full capacity, MCTs are expected to carry a caseload of 40 clients.

The attached MAMA's Budget Justification Table provides support for the payment rates. Costs included in this justification include staffing costs, including the operation of a perinatal high risk team and an administrative support team, certain contract costs for mental health related services, and other supplies and expenses. Descriptions of the responsibilities of each team, and their projected makeup, are included. Staffing levels were determined by the estimated work load, average daily productivity, average days worked in a year, and an assessment of expected utilization for the target population. The payment rates reflect a TCM adjustment of 22-24% for the cost of the perinatal high risk team. Cost estimates used to build the payment rates for the PMPM program reflect assumptions about staffing models and supply costs that equal, over the course of the program, the projected cost of the program. However, costs for individual years may be higher or lower due to the expected rapid ramp up of the program in the early years and economies of scale achieved in the later years.

Table 5.5a: Staffing Model Description

| Program | Explanation of Staffing Model* |
|---|---|
| Homeless Care Support Services (HCSS) | HCSS is a care management program in which a care manager will carry a caseload that is weighted based on client risk. HCSS will risk stratify clients into 3 categories: low acuity, high acuity, and bridged (clients in interim housing). Caseloads for care managers will range from 40 clients/care manager (low acuity) to 20 clients/care manager (high acuity and bridge). |
| Benefits Advocacy | Benefits Advocacy is a navigation program in which a benefits advocacy specialist will manage a caseload of up to 100 clients |
| Recuperative Care | Recuperative care is a facilities-based program. We will deliver care across multiple facilities with 42 Full Time Equivalents (FTE) in total clinical staff. For |

| | |
|---|---|
| | psychiatric recuperative care will be delivered in up to 200 beds across multiple facilities with up to 27 FTEs in the total clinical care team. |
| Sobering Center | Sobering center is a facilities-based program. We will deliver care in up to 150 beds across multiple facilities with 52 FTE total clinical staff by year 5 |
| Tenancy Support Services (TSS) | TSS is a housing navigation program in which a housing coordinator will carry a caseload of up to 100 clients |
| Re-entry | Re-entry is a care management program in which a CHW care manager will carry a caseload of 30 clients for the following re-entry programs: Community Re-entry Adult Jail, Community Re-entry Adult Extended Care, and Enhanced Care Coordination Re-entry.<br>The Community Re-entry Adult Community Referral CHW will hold a caseload of 15 clients.<br>Community Re-entry Juvenile Aftercare CHWs will hold a caseload of 15 clients throughout the duration of the program. |
| Residential and Bridging Care (RBC) | RBC is a team-based care coordination program in which a care management team of 24 FTEs will provide 1,800 member months of services by year 3 |
| Intensive Service Recipients (ISR) | ISR is a team-based care coordination program in which a care management team of 37 FTEs will provide 3,840 member months of service by year 4 |
| Kin to peer (KTP) | KTP is a team-based care coordination program in which a CHW care manager will carry a caseload of 10 clients |
| Substance Use Disorder-Engagement, Navigation, and Support (SUD-ENS) | SUD-ENS is a care management program in which a CHW care manager will carry a caseload of 30 clients |
| Medically Complex – Transition of Care (TOC) | TOC is a care management program in which a CHW care manager will carry a caseload of 25 clients |
| MAMA's Neighborhood | MAMA's is a team-based care coordination program in which each care team will carry a caseload of 40 clients |

* Both considerations related to space configurations and the geographic distribution of programs may impact our staffing model.

## Pay for Reporting

For reporting on the variant WPC-LA metrics required as part of the pilot, the pilot would earn $1,500,000 in PY 2, and $1,000,000 in PY 3 through PY 5. These payments reflect the value to WPC-LA and to DHCS in having timely, accurate, and complete data regarding key aspects of the operation of WPC-LA. This data will also support PDSA cycles that inform the future direction of WPC-LA. Proportional payment would be available based on the number of variant metrics for which reporting is timely completed. No funding is requested for the reporting of universal metrics. The increased funding available for PY2 is in recognition of the intensive activities associated with developing the required metrics for reporting during the initial Round 2 expansion year, which will be leveraged in PY3-5, and in recognition of the costs and burden associated with developing, submitting an approved application to expand WPC-LA in Round 2.

## Pay for Outcome Achievement

The WPC-LA Budget includes a WPC Incentive Pool that rewards the WPC-LA for achieving key process and metric outcomes achievements that are the highest priorities for our target populations. Each incentive payment is earned based on the Pilot's performance in one or more related measures, e.g., measures related to improving the health of a particular WPC-LA target population. The full amount of

the incentive payment may be earned by achieving the incentive target, as calculated on a point system that reflects the relative value of the measures listed for that incentive. Reduced payment is available for partial performance toward the incentive target, but no payment will be earned if the applicable points are less than a minimum threshold (generally 50% of the incentive target). Points earned for each measure may range from 0 to the amount listed in the tables below.

The incentive payment amounts were established to reflect their value to advancing the effectiveness of the program component and the overall WPC-LA objectives. The maximum amount of payments from the WPC Incentive Pool for each year is listed below, followed by a description of the incentives and measures and applicable point methodology. Payments for reporting and incentive payments for project milestones and incentive payments to downstream providers are paid separately from the WPC Incentive Pool.

WPC Incentive Pool – Budget Amounts (aggregate of maximum amounts for incentives listed below)

| | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| Maximum Incentive Pool Payments | $31,800,000 | $34,800,000 | $31,550,000 | $27,300,000 |

1. Primary Care Engagement Incentive. This incentive payment will be earned for achieving a target of 50% achievement of primary care provider notification of enrollment in WPC-LA programs. Payments shall be reduced by 4% for every 1% short of this goal.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 50% Primary Care Notification of enrollment in WPC-LA programs | $800,000 | $800,000 | $800,000 | $800,000 |

2. Homeless High-Risk Incentive. This incentive payment will be earned for completing critical processes in homeless high-risk programs that support achievement of WPC-LA outcomes, as measured by multiple metrics (listed below). To evaluate success, a point system that reflects the value of the individual metrics will be used, as described below. The amounts below will be paid if WPC-LA achieves the target points identified below for a given year, with partial payment available in proportion to the score, provided a minimum of 50% of the target points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 1,050 Points earned in PY2, 1,000 Points earned in PY3 and PY4, and 650 Points earned in PY5 (minimum 525, 500, 500, and 325, respectively, for partial payment) | $5,250,000 | $5,000,000 | $5,000,000 | $3,250,000 |

| Metrics | Goal | Points |
|---|---|---|
| Proportion of recuperative care clients linked to permanent housing at discharge from recuperative care | 40% | 150 points (PY2)<br>100 points (PY3-4)<br>(Lose 10 points for every 1% short of goal) |
| Proportion of psychiatric recuperative care clients linked to permanent housing at discharge from recuperative care | 40% | 100 points in PY2<br>200 points (PY3-5)<br>(Lose 20 points for every 1% short of goal) |
| Proportion of Benefits Advocacy clients whose complete and submitted application is approved | 60% | 150 points (PY2-5)<br>(Lose 10 points for every 1% short of goal) |
| Proportion of HCSS workers trained in healthcare system navigation, health coaching and behavior modification support, and medication adherence protocols through the WPC-LA Training Institute within 6 months of hire or program start | 50% | PY2: 300 points<br>(Lose 20 points for every 1% short of goal)<br><br>PY3-4: 250 points<br>(Lose 20 points for every 1% short of goal)<br><br>PY5: 150 points<br>(Lose 10 points for every 1% short of goal) |
| Proportion of HCSS workers trained in motivational interviewing, harm reduction, the recovery model, and trauma-informed care through the WPC-LA Training Institute within 6 months of hire or program start | 50% | PY2: 300 points<br>(Lose 10 points for every 1% short of goal)<br><br>PY3-4: 250 points<br>(Lose 20 points for every 1% short of goal)<br><br>PY5: 150 points<br>(Lose 10 points for every 1% short of goal) |
| Proportion of Psychiatric Recuperative Care staff trained in de-escalation strategies and techniques | 50% | PY2-4: 150 points<br>(Lose 20 points for every 1% short of goal) |
| Clients enrolled in WPC programs through Street Team outreach programs | 100 enrolled (PY2-5) | PY2-5: 200 points |

3. Justice Involved High-Risk Incentive. This incentive payment will be earned for completing critical processes in the justice high-risk programs that support achievement of WPC-LA outcomes, as measured by multiple metrics (listed below). To evaluate success, a point system that reflects the value of the individual metrics will be used, as described below. The amounts below will be paid if WPC-LA achieves the target points identified below for a given year, with

partial payment available in proportion to the score, provided a minimum of 50% of the target points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 1,875 points earned in PY2, 2,150 Points earned in PY3, 1,950 Points earned in PY4, and 1,650 Points earned in PY5 (minimum 937, 1,075, 975, and 825 points, respectively, for partial payment) | $9,375,000 | $10,750,000 | $9,750,000 | $8,250,000 |

| Metrics | Goal | Points |
|---|---|---|
| Proportion of adult justice-involved individuals who receive a 30-day supply of chronic medications in their first month of the program | 75% | 300 points (Lose 10 points for every 1% short of goal) |
| Proportion of adult justice-involved high-risk individuals engaged by Re-entry team within 5 business days of release | 50% | 250 points (Lose 10 points for every 1% short of goal) |
| Proportion of adult justice-involved high-risk individuals linked to primary care w/in 1 month of release or 1 month of program entry | 40% | 300 points (Lose 20 points for every 1% short of goal) |
| Proportion of Re-entry CHWs trained in healthcare system navigation, health coaching and behavior modification support, and medication adherence protocols through the WPC-LA Training Institute within 6 months of hire or program start | 50% | PY2-4: 250 points (Lose 20 points for every 1% short of goal) PY5: 150 points (Lose 10 points for every 1% short of goal) |
| Proportion of Re-entry CHWs trained in motivational interviewing, harm reduction, the recovery model, and trauma-informed care through the WPC-LA Training Institute within 6 months of hire or program start | 50% | PY2-4: 250 points (Lose 20 points for every 1% short of goal) PY5: 150 points (Lose 10 points for every 1% short of goal) |
| Number of Juvenile justice-involved receiving a jobs program | 60 | 600 Points (Reduce by 30 points for every 3 short of target) |
| Proportion of juvenile justice individuals who receive a 30-day supply of medications in their first month of the program | 75% | 100 points (Lose 30 points for every 1% short of goal) |

| | | |
|---|---|---|
| Proportion of Juvenile justice-involved high-risk individuals engaged by Re-entry team within 5 business days of release | 50% | 100 points<br>(Lose 20 points for every 1% short of goal) |
| Proportion of juvenile justice-involved high-risk individuals linked to primary care w/in 1 month of release or 1 month of program entry | 40% | 100 points<br>(Lose 20 points for every 1% short of goal) |
| Number of Mental Evaluation Team (MET) encounters | PY2: 1,000 encounters<br>PY3: 4,000 encounters<br>PY4: 2,000 encounters | PY 2: 100 points<br>PY3: 400 points<br>PY4: 200 points<br>(Reduce by 10 points for every 100 short of target) |

4. Behavioral Health and Medical High-Risk Programs Incentive. This incentive payment will be earned for completing critical processes in the Behavioral Health (ISR, TBC, SUD-ENS, and KTP) and Medical High-Risk (TOC and MAMA's) programs that support achievement of WPC-LA outcomes, as measured by multiple metrics (listed below). To evaluate success, a point system that reflects the value of the individual metrics will be used, as described below. The amounts below will be paid if WPC-LA achieves the target points identified below for a given year, with partial payment available in proportion to the score, provided a minimum of 50% of the target points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 1,050 points earned in PY2, 1,200 points in PY3, 1,200 points in PY4, and 1,000 in PY5 (minimum 525, 600, 600, 500 points for partial payment) | $5,250,000 | $6,000,000 | $6,000,000 | $5,000,000 |

| Metrics | Goal | Points |
|---|---|---|
| Proportion of mental health high-risk individuals receiving a post-discharge home visit within 5 business days of discharge from a psychiatric inpatient facility | 40% | 150 points (Lose 10 points for every 1% short of goal) |
| Proportion of psych inpatient and IMD patients who have Multnomah Community Ability Scale scores or applicable instruments consistent with community placement that are engaged by the Residential & Bridging Care Transition Team | 40% | 150 points (Lose 10 points for every 1% short of goal) |
| Proportion of medical high-risk individuals with pre-discharge hospital visit OR home visit within 3 business days of discharge | 40% | 200 points (Lose 10 points for every 1% short of goal) |
| Proportion of medical high-risk individuals scheduled in primary care within 1 month of discharge | 40% | 150 points (Lose 10 points for every 1% short of goal) |
| Proportion of KTP clients receiving a visit within 5 business days of referral | 50% | 150 points (Lose 10 points for every 1% short of goal) |
| Number of mental health high-risk individuals receiving services in Placement Support Initiative | Number served | PY 2&5: 250 Points (1 point for every person served)<br><br>PY3&4: 500 points (1 point for every person served) |
| Proportion of perinatal high-risk individuals with a completed care plan within 1 month of referral | 50% | 250 points (Lose 10 points for every 1% short of goal) |

5. Critical Program Support Incentive. This incentive payment will be earned for completing critical processes to support performance improvement, access to WPC-LA programs, and provide legal support to WPC Clients and the achievement of WPC-LA outcomes, as measured by multiple metrics (listed below). To evaluate success, a point system that reflects the value of the individual metrics will be used, as described below. The amounts below will be paid if WPC-LA achieves the target points identified below for a given year, with partial payment available in proportion to the score, provided a minimum of 50% of the target points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 580 Points earned in PY2, 1,280 Points earned in PY3, 1,200 Points earned in PY4, and 1,100 Points earned in PY5 (minimum 290 points, 640 points, 600 | $2,900,000 | $6,400,000 | $6,000,000 | $5,500,000 |

| | | | | |
|---|---|---|---|---|
| points, and 550 Points for partial payment, respectively) | | | | |

| Metrics | Goal | Points |
|---|---|---|
| Number of months that a whole person care quality dashboard is published | 12 months | PY2: 150 points<br>PY3-5: 300 points<br>(lose 25 points for every month not produced) |
| Timely production of an annual WPC program sustainability report | November 1st of each program year | PY2-5: 400 points<br>(Lose 20 points per week delayed) |
| WPC Referral Access Line & Call center operating a minimum of 300 days a year | | PY3-5: 400 points<br>(Lose 20 points per every 7 days not operating) |
| Number of medical-legal service entities contracted to provide medical-legal services | Entities contracted: 5 each in PY2&3 | PY 2&3: 100 points (Lose 20 points per entity not contracted) |
| WPC-LA clients served through a medical-legal partnership | 300 in PY2 -5 | PY2: 100 points<br>PY 3&4: 400 points<br>PY 5: 300 points<br>(Lose 25 points per every 25 clients short of goal) |

6. Housing Outcomes Incentive. This incentive payment will be earned for achieving high-value housing outcomes through the operation of the Homeless High-Risk programs, as measured by multiple metrics (listed below). To evaluate success, a point system that reflects the value of the individual metrics will be used, as described below. The amounts below will be paid if WPC-LA achieves the target points identified below for a given year, with partial payment available in proportion to the score, provided a minimum of 50% of the target points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 650 Points earned (minimum points for partial payment) | $3,250,000 | $3,250,000 | $3,250,000 | $3,250,000 |

| Metrics | Goal | Points |
|---|---|---|
| Proportion of clients housed by WPC-LA who are permanently housed for >6 months | 75% | 350 points (Lose 10 points for every 1% short of goal) |
| Proportion of clients permanently housed by WPC-LA who are housed on a federal HUD housing voucher | 25% | 150 points (Lose 10 points for every 1% short of goal) |
| Number of homeless WPC-LA clients placed into housing over the course of WPC-LA | 2,400 clients by end of PY2; 4,800 clients by end of PY3; 7,200 clients by end of PY4; 9,600 clients by end of PY5 | 360 points (Lose 30 points for every 200 people short of goal) |

7. Clinical Outcome Incentives. This incentive payment will be earned for achieving high-value clinical outcomes through the operation of the WPC-LA programs, as measured by multiple metrics (listed below). To evaluate success, a point system that reflects the value of the individual metrics will be used, as described below. The amounts below will be paid if WPC-LA achieves the target points identified below for a given year, with partial payment available in proportion to the score, provided a minimum of 50% of the target points are achieved.

| Incentive Target | Y2 | Y3 | Y4 | Y5 |
|---|---|---|---|---|
| 500 Points earned (minimum 250 points for partial payment) | $2,500,000 | $2,500,000 | $2,500,000 | $2,500,000 |

| Metrics | Goal | Points |
|---|---|---|
| 30-day all cause hospital readmissions from a WPC-LA recuperative care facility | 2% reduction per year from baseline | 200 points (Lose 30 points for every 0.2% short of goal reduction) |
| Readmissions/admission to an inpatient mental health facility within 30 days post-discharge from a psychiatric inpatient unit or an IMD facility with WPC-LA support | 2% reduction per year from baseline | 225 points (Lose 30 points for every 0.2% short of goal reduction) |
| 30-day all cause readmissions for medical high-risk individuals | 2% reduction per year from baseline | 225 points (Lose 30 points for every 0.2% short of goal reduction) |

Acronyms

| Acronym | Definition |
|---|---|
| ADT | Admission/Discharge/Transfer |
| AHO | Area Health Officer |
| AOD | Alcohol and Other drugs |
| ARF | Adult Residential Facility |
| CA | Custody Assistants |
| CAU | Camp Assessment Unit |
| CBO | Community Based Organization |
| CDCR | California Department of Corrections and Rehabilitation |
| CEDAR | Comprehensive Enterprise Data and Analytics Repository |
| CES | Coordinated Entry System |
| CHW | Community Health Worker |
| CIT | Crisis Intervention Team |
| CMP | Care Management Platform |
| CoC | Continuum of Care |
| CRDF | Century Regional Detention Facility |
| CRRC | Community Re-entry and Resource Center |
| CRT | Crisis Resolution Team |
| CRM | Countywide Resource Management |
| CWMDM | Countywide Master Data Management |
| DHCS | California Department of Health Care Services |
| DCFS | Department of Children and Family Services |
| DHS | Department of Health Services |
| DMH | Department of Mental Health |
| DPH | Department of Public Health |
| DPSS | Department of Social Services |
| ED | Emergency Department |
| HER | Electronic Health Record |
| EMT | Emergency Medicine Technician |
| ERS | Enriched Residential Setting |
| FHSP | Flexible Housing Subsidy Pool |
| FSP | Full Service Partnership |
| FTE | Full-Time Employee |
| HACLA | Housing Authority of the City of Los Angeles |
| HACoLA | Housing Authority of the County of Los Angeles |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HCSS | Homeless Care Supportive Services |
| HIE | Health Information Exchange |
| HMIS | Homeless Management Information System |
| IMD | Institutions for Mental Diseases |

| Acronym | Definition |
|---|---|
| IT | Information Technology |
| ISR | Intensive Service Recipient |
| JHIS | Jail Health Information System |
| KTP | Kin to peer |
| LAC | Los Angeles County |
| LAHSA | Los Angeles Homeless Services Authority |
| LANES | Los Angeles Network for Enhanced Services |
| LASD | Los Angeles County Sheriff's Department |
| LCSW | Licensed Clinical Social Worker |
| LOS | Length of Stay |
| LPS | Lanterman-Petris-Short Act |
| MCW | Medical Case Worker |
| MCT | Mobile Care Team |
| MDA | Multi-Disciplinary Assessment |
| MDT | Multi-Disciplinary Team |
| MET | Mental Evaluation Team |
| MFT | Medical Family Therapy |
| MHCL | Mental Health Consult Line |
| MLCP | Medical-Legal Community Partnership |
| NFP | Nurse Family Partnership |
| ODS | Organized Delivery System |
| OPI | Office of Performance Improvement |
| PDSA | Plan-Do-Study Act |
| PES | Psychiatric Emergency Services |
| POC | Point-of-Care |
| RBC | Residential and Bridging Care |
| PSI | Placement Support Initiative |
| RCC | Regional Coordinating Center |
| | |
| SAPC | Substance Abuse Prevention and Control |
| SPA | Service Planning Area |
| SMI | Severe Mental Illness |
| SSI | Social Security Income |
| SSDI | Social Security Disability Insurance |
| SUD | Substance Use Disorder |
| SUD-ENS | Substance Use Disorder Engagement, Navigation, and Support |
| TOC | Transitions of Care |
| WPC-LA | Whole Person Care Los Angeles |
| WRAP | Wellness Recovery Action Plan |

**WPC Budget Template: Summary and Top Sheet**

| | |
|---|---|
| **WPC Applicant Name:** | County of Los Angeles - Department of Health Services |

| | Federal Funds | IGT | Total Funds |
|---|---|---|---|
| **Annual Budget Amount Requested - PY1** | 90,000,000 | 90,000,000 | 180,000,000 |
| **Annual Budget Amount Requested - PY2** | 115,739,454 | 115,739,454 | 231,478,908 |
| **Annual Budget Amount Requested - PY 3-5** | 141,478,909 | 141,478,909 | 282,957,818 |

| **PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)** | |
|---|---|
| **PY 1 Total Budget** | 180,000,000 |
| *Approved Application (75%)* | 135,000,000 |
| *Submission of Baseline Data (25%)* | 45,000,000 |
| **PY 1 Total Check** | OK |

| **PY 2 Budget Allocation** | | Total | Amount over 231,478,908 | Round 1 #s |
|---|---|---|---|---|
| **PY 2 Total Budget** | 231,478,908 | | | 180,000,000 |
| *Administrative Infrastructure* | 28,492,733 | | | 23,886,512 |
| *Delivery Infrastructure* | 9,311,160 | | | 6,111,160 |
| *Incentive Payments* | 44,775,000 | | | 32,750,000 |
| *FFS Services* | 6,066,142 | | | 6,066,228 |
| *PMPM Bundle* | 112,008,873 | | | 100,070,048 |
| *Pay For Reporting* | 1,500,000 | | | 500,000 |
| *Pay for Outcomes* | 29,325,000 | | | 10,616,052 |
| **PY 2 Total Check** | OK | 231,478,908 | 0 | |

| **PY 3 Budget Allocation** | | | | |
|---|---|---|---|---|
| **PY 3 Total Budget** | 282,957,818 | | | 180,000,000 |
| *Administrative Infrastructure* | 32,091,488 | | | 21,321,485 |
| *Delivery Infrastructure* | 4,828,754 | | | 4,828,754 |
| *Incentive Payments* | 23,525,000 | | | 8,500,000 |
| *FFS Services* | 8,640,432 | | | 8,640,536 |
| *PMPM Bundle* | 178,172,144 | | | 125,247,856 |
| *Pay For Reporting* | 1,000,000 | | | 500,000 |
| *Pay for Outcomes* | 34,700,000 | | | 10,961,369 |
| **PY 3 Total Check** | OK | 282,957,818 | 0 | |

| **PY 4 Budget Allocation** | | | | |
|---|---|---|---|---|
| **PY 4 Total Budget** | 282,957,818 | | | 180,000,000 |
| *Administrative Infrastructure* | 31,177,281 | | | 21,868,375 |
| *Delivery Infrastructure* | 4,885,636 | | | 4,885,636 |
| *Incentive Payments* | 6,675,000 | | | 4,000,000 |
| *FFS Services* | 8,912,415 | | | 8,912,534 |
| *PMPM Bundle* | 197,007,486 | | | 128,559,181 |
| *Pay For Reporting* | 1,000,000 | | | 500,000 |
| *Pay for Outcomes* | 33,300,000 | | | 11,274,275 |
| **PY 4 Total Check** | OK | 282,957,818 | 0 | |

| **PY 5 Budget Allocation** | | | | |
|---|---|---|---|---|
| **PY 5 Total Budget** | 282,957,818 | | | 180,000,000 |
| *Administrative Infrastructure* | 31,411,884 | | | 22,420,380 |
| *Delivery Infrastructure* | 4,880,927 | | | 4,880,927 |
| *Incentive Payments* | 2,925,000 | | | 2,000,000 |
| *FFS Services* | 9,179,788 | | | 9,179,933 |
| *PMPM Bundle* | 208,510,219 | | | 133,906,717 |
| *Pay For Reporting* | 1,000,000 | | | 500,000 |
| *Pay for Outcomes* | 25,050,000 | | | 7,112,043 |
| **PY 5 Total Check** | OK | 282,957,818 | 0 | |