Whole Person Care:

A Mid-Point Check-In

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HC HARBAGE CONSULTING

On any given day, between 50,000 - 60,000 people experience homelessness in Los Angeles County. Many of these people have mental health or substance use disorders and are disconnected from friends, family, and other social supports. In 2017, Los Angeles County created new resources to address these challenges. Through the Los Angeles County Whole Person Care (WPC) pilot program, authorized under California's Medi-Cal 2020 Section 1115 waiver, the county opened the Dr. David L. Murphy Sobering Center.

The Sobering Center offers intoxicated people experiencing homelessness in Los Angeles County a clean and safe environment to recuperate. The center also offers medical triage services, Medi-Cal enrollment, and referrals to mental health and substance use treatment services. Since opening, the Sobering Center, located in downtown Los Angeles, has served more than 4,868 unduplicated clients between March 2017 and November 2018.

In addition to the Sobering Center, Los Angeles County offers the Homeless Care Support Services (HCSS) program through WPC. HCSS provides Medi-Cal beneficiaries experiencing homelessness with comprehensive wrap-around services to improve health, address housing needs, and decrease the use of high-cost health care services. Participants are connected to permanent housing opportunities and receive rent subsidies either through Section 8 federal funding or through the county's flexible housing pool funds. Thus far, Los Angeles County has enrolled 13,449 unique Medi-Cal beneficiaries in HCSS.

Introduction

Los Angeles County is one of 25 WPC pilots across the state of California (see Exhibit 1) providing services that are not traditionally covered by Medi-Cal. The goal of WPC is to coordinate health, behavioral health, and social services for high-risk Medi-Cal enrollees and provide additional services to address the social determinants of health.

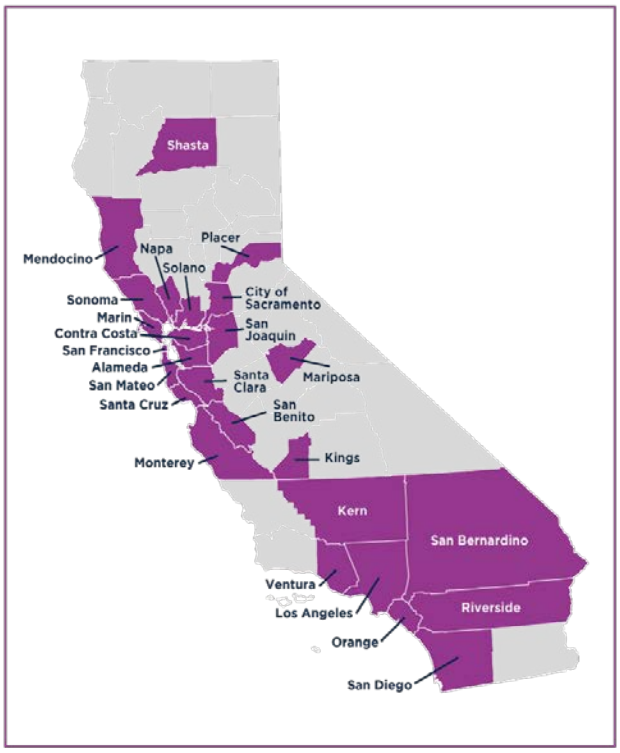

Exhibit 1: Map of WPC Pilots

The WPC program is the nation's first to encourage counties, cities, hospital authorities, health plans, providers and community-based organizations (CBOs) to harness their collective resources to identify and provide essential wrap-around services to Medi-Cal beneficiaries, many of whom are homeless, justice-involved, and/or have traditionally been high-utilizers of emergency medical care. WPC not only provides funding for the delivery of these wrap-around services but acts as a catalyst for systemic change at the local level by allowing pilots the flexibility to meet beneficiary needs in creative ways rather than through a set menu of covered services. Essential to this flexibility are the pilots' investments into care coordination infrastructure and workflows, which have the potential to last long beyond the pilot timeframe.

This paper provides insights into WPC program implementation and discusses pilot accomplishments and current challenges. The learnings shared in this paper are drawn from the WPC Learning Collaborative,[i] one-on-one interviews with all 25 pilots, and in-depth interviews with three programs (Alameda County, Los Angeles County, and Placer County).

What is California's Whole Person Care Pilot Program?

Recognizing that medical services only address part of a person's overall health care status the California Department of Health Care Services (DHCS) designed the WPC program to address the health, behavioral health, and social needs of high-need, high-cost Medi-Cal beneficiaries, and negotiated the program as part of its Medi-Cal 2020 Section 1115 waiver renewal with the Centers for Medicare & Medicaid Services (CMS).[ii] The WPC pilots are testing whether local initiatives coordinating physical health, behavioral health, and social services (housing supports, food assistance, General Assistance, Supplemental Security Income, etc.) can improve health outcomes and reduce medical costs. Up to $1.5 billion in federal funds are available over the five years of the demonstration, matched by $1.5 billion in local funds from the pilots. Each WPC pilot differs in size, target population(s), and interventions based on community needs, priorities, and resources. Program elements that are common across many pilots include:

"WPC is unique in providing flexibility and accountability, in breaking down trust barriers, and allowing us to address the root cause of the barriers our members face."
– San Diego County Health and Human Services Agency

- ***Community Health Workers*:** Many of the pilots are integrating community health workers (CHWs) into their workforce in order to improve outreach and provide care coordination services to WPC enrollees.
- ***Service Navigation Centers/Support*:** Some pilots are creating hubs of information for enrollees to help them efficiently learn about and connect to services. CHWs or other outreach workers and peer support staff help enrollees fill out applications for social services including food assistance, General Assistance, Meals on Wheels and more.
- ***Reentry Transitions:*** Pilots focusing on the reentry population are working closely with corrections departments, including probation, courts, and the local county jail system to improve transitions once individuals are released from jail.
- ***Housing Supportive Services:*** A majority of pilots are using WPC to offer housing supportive services, including housing navigation and tenancy support, in an effort to help WPC enrollees find housing placements and stay in those placements for the long-term.
- ***Medical Respite/Recuperative Care*:** Many pilots are using WPC funding to develop medical respite or recuperative care centers for homeless enrollees who

are too sick to be on the streets but not sick enough to be admitted to the hospital, or who need a safe place to stay post-discharge.

- ***Sobering Centers:*** Many pilots are using WPC funding to build sobering centers that provide a safe space for intoxicated individuals experiencing homelessness to recover.

Sobering Centers

Sobering Centers are alternatives to jail or the ER for non-offending enrollees who need a safe space to recuperate. Santa Clara County is partnering with its Sheriff's department and Santa Clara Valley Medical Center Hospital and Clinics to ensure those who encounter these individuals know the sobering centers exist and how to refer individuals to them. Pilots have learned that they need to communicate closely with the local police and Sheriff's departments to ensure eligible individuals are brought to the centers rather than the ER. Kings County learned the importance of placing the sobering center at a convenient location for police officers (e.g., not on the outskirts of town) in order to ensure it is just as or more convenient to use than the local hospital ER or jail, which are centrally located. Having learned this lesson, Kings County is in the process of relocating its sobering center.

Application Process

DHCS designed a robust application process for counties interested in participating in WPC. Pilots outlined the criteria used to identify their target populations, the unmet need for services in their geographical areas, proposed services that are not otherwise provided by Medi-Cal, community partners (including participating health plans, providers, and social service providers), a set of metrics that they would track and report in addition to the required universal metrics, and a detailed budget outlining predicted expenditures based on how they would deliver services or achieve outcomes.

DHCS approved eighteen pilots in November 2016 for an implementation date of January 1st, 2017, and an additional seven pilots in June 2017, for an implementation date of
July 1, 2017. The demonstration will run through December 31, 2020.[iii]

"WPC is an incredible opportunity. The county can provide services not historically eligible for Medi-Cal reimbursement, but with that flexibility comes the necessity to be accountable to improve the lives of those who live on the margins by way of improving health outcomes demonstrating long term value."

– Placer County Health and Human Services Agency

Target Populations

While all pilots target high-needs Medi-Cal beneficiaries, pilots were able to further define their populations based on a community needs assessment as a part of their application development. Target populations identified by the pilots include:

- Individuals who are homeless/at-risk for homelessness;
- High utilizers[iv] with repeated incidents of avoidable Emergency Department (ED) use, hospital admissions, or nursing facility placement;
- Individuals with mental health and/or substance use disorder (SUD) conditions;
- Individuals recently released from institutions (e.g. hospital, jail, Institution for Mental Diseases (IMD), or skilled nursing facility);
- High utilizers with two or more chronic conditions;
- High-risk pregnant mothers; and
- Individuals with cognitive impairment.

Reentry

Assisting individuals who are being released from jail is the focus of several of the WPC pilots. Kings County has a strong relationship with the primary care provider in the jail, which has helped to facilitate notifications and warm hand-offs when individuals are released.

Los Angeles County has created a reentry program that provides several types of services while a person is still in jail. Pre-release services include:

- Conducting a comprehensive psychosocial assessment and developing a re-entry care plan in collaboration with the participant;
- Arranging for Medi-Cal enrollment starting at jail intake for activation after release;
- Providing a 30-day supply of prescription medication at release for participants with chronic health or mental health conditions; and
- Arranging transportation, shelter, or other services for those being released with little notice.

Financing Structure

As part of the WPC application, pilots requested an annual dollar amount that specified payments for proposed elements of their pilots, including infrastructure development, data collection, interventions, outcomes, and incentives. The budget is the same year over year. Every six months, pilots submit financial reports that detail the number of enrolled participants and costs linked to the completed activities specified in their budgets.

Once DHCS verifies the accuracy of each pilot's financial report, the pilot's lead entity (see Appendix A) transfers local matching funds to DHCS, which then transfers the funds to the federal government, where they are matched by federal Medicaid dollars. The federal governmental pays the combined gross amount, which is paid back to DHCS, which in turn transfers the funds to the pilot through an intergovernmental transfer (IGT).

Pilots are responsible for disbursing funds in accordance with the terms of their approved application. Pilots include both fee-for-service and per-member-per-month (PMPM) mechanisms to draw down payments, enabling pilots to implement value-based payment models, including incentive payments, to achieve pilot goals. The PMPM payment model, which every pilot uses, requires trust-building and infrastructure development for the organizations serving Medi-Cal beneficiaries, many of whom are used to cost-based reimbursement (particularly for behavioral health services) and have had little experience with value-based payment mechanisms. Pilots have reported that this flexibility and new way of thinking about accountability has allowed them to provide the services beneficiaries need and allows providers to employ a "do whatever it takes" approach to serving clients, rather than focusing on providing a prescribed set of services.

In order to develop buy-in for their PMPM model, the Marin County pilot ramped up slowly and initially enacted contracts for only half of their planned case management capacity. They did this in order to allow their partners to see how the program worked and develop trust in PMPM payments. Once partners understood the value of the pilot and gained confidence in the new payment method, Marin moved towards building out full case management capacity.

Another example of financing flexibility in WPC is that DHCS allows pilots to "roll over" funding that they were unable to spend in the previous program year. Through the roll-over process, pilots are able to reallocate funding earmarked for one payment category (e.g. developing a sobering center) to another category (e.g. providing respite care). This process is essential to pilots as they discover unanticipated road blocks and opportunities while implementing their programs.

Outcomes Measurement

Starting in the second program year (PY), which began in July 2017, pilots began submitting reports detailing spending and outcomes metrics (see Appendix B). All pilots must report on selected universal and variant metrics and demonstrate a link between funding and the achievement of outcomes. Examples of universal and variant metrics include both NCQA and HEDIS measures, and newly-developed, county- and population-specific measures identified by pilots as outcomes that could be derived

from data collected as part of the pilot. The UCLA Center for Health Policy Research, the external evaluator for the program, will use this data to evaluate the impact of WPC.

WPC Implementation: Lessons Learned and Remaining Challenges

Now in PY 4, all 25 pilots are well into program implementation. Though pilots vary in focus and scope, all acknowledge that WPC has provided them with the opportunity to address the needs of Medi-Cal beneficiaries who have historically fallen through the safety net. Through interviews and Learning Collaborative activities, pilots have described accomplishments and current challenges, summarized below.

Building Partnerships

Through WPC, pilots have developed or strengthened relationships with partners including local health and social service agencies, Medi-Cal Managed Care Plans (MCPs), hospitals, providers, and community-based organizations (CBOs) that have the potential to play an important role in serving clients and improving health outcomes. Nearly all pilots have described relationship-building and "silo-busting" as some of the biggest accomplishments of WPC and the ones most likely to be sustained once the program concludes. Because local governments serve as a hub for the pilots, they have the influence and resources necessary to convene partners, both internally within government systems and externally with community-based partners, both of which are essential to supporting Medi-Cal beneficiaries with new services and a person-centered approach to care.

Developing and maintaining these partnerships is a resource-intensive undertaking. Many pilots allocated resources specifically to partnership development, dedicating staff time to go to meetings that do not directly relate to the WPC pilot in order to establish rapport with partners and demonstrate their willingness to support partner goals. Many pilots formed work groups or advisory committees during the application development process and continue to meet during implementation. Convening face-to-face meetings with partners helped pilots develop relationships, establish buy-in, and facilitate direct conversations about processes, work flows, and challenges. To encourage morale among partners, many pilots share success stories during partnership meetings. The Kings, Monterey, Sacramento, San Mateo, Santa Clara, Shasta, and San Joaquin pilots have all started collecting and sharing success stories among their partners, in some cases sharing them at county Board meetings or steering committee meetings that usually include partner agencies, MCPs, hospitals, providers, and CBOs.

Internal Partnerships

Early on, many WPC pilots described intra-governmental silos and fragmentation as challenges, whether or not the health and behavioral health divisions are separate agencies or housed under a single agency model. Historically many county agencies,

including county public health, behavioral health, Medi-Cal eligibility and enrollment, and corrections serve the same county residents but have not communicated and coordinated with each other effectively. Under WPC's mission and funding, pilots are empowered to bring these partners to the table to work on coordinating care for their shared population.

In developing partnerships that did not previously exist, pilots encountered intra-agency communication, culture, and system challenges. Despite having departments and divisions under the same county infrastructure and leadership, pilots worked through several issues:

- ***Communication:*** WPC created the opportunity and mechanism for intra-governmental partners to come together in regular planning and operations meetings to discuss workflows and conduct case conferences. These meetings increase cross-agency awareness and understanding, improve working relationships, and result in better coordination for beneficiaries. County staff report being more aware of who to call for help or referrals for clients. Significant barriers exist, however, for county agencies that have historically had their own processes for connecting residents to specific resources involving stand-alone data systems. Although many pilots have learned or are learning how to share data and communicate across county departments, understanding which data can be shared among partners and how to share it effectively and efficiently remains a challenge (see further discussion below).
- ***Cultural differences:*** While WPC partner agencies all play a role in the lives of WPC target populations, traditionally, the way they address the needs of these individuals has varied. For example, the county justice system has historically focused on the potential criminal aspects of substance use or homelessness, and their ability to connect those experiencing homelessness or substance use disorders with care has been less clear. Through WPC, pilots that are targeting the reentry and homeless populations have broadened options for justice-involved individuals. By creating warm-hand offs for individuals leaving jail and in need of mental health or substance use services, jail and probation staff have new resources and a direct mechanism to connect individuals to needed services. WPC helps broaden siloed county functions from "my focus" to "our focus."

  For example, the Riverside County WPC pilot works in partnership with county probation officers to determine resources and services for their mutual clients. Probation officers regularly reach out to WPC staff on behalf of probationer with needs for behavioral and physical health, housing, and social services. Probation officers acknowledge that the program has helped them to more efficiently and effectively address the health needs of the people in their care.

- ***Administrative processes:*** Pilots have struggled with internal administrative processes that make hiring staff and contracting with vendors challenging. Pilots have worked creatively with human resources and legal departments to expediate hiring and procurement processes, all while ensuring that they are taking the appropriate steps to protect enrollee data and be mindful of county administrative processes.

Pilots have worked diligently to improve communication and reduce barriers among internal city and county departments. Though much of the communication and partnership infrastructure developed through the pilots is fairly straightforward, it took the mission of the WPC program and its resources dedicated to building care coordination to enable pilots to take these steps.

External Partnerships

In addition to breaking down internal silos, WPC pilots are building closer working relationships with MCPs, hospitals, community health centers, and CBOs such as housing providers. These organizations have long played a role in caring for the Medi-Cal population, and pilots have made great strides in developing, maintaining, and expanding partner relationships:

"We remind the team that this is one of the important things we are doing—it's not just serving the clients, but also building relationships."
– *Placer County Health and Human Services Agency*

- ***Health plans:*** MCPs are required partners for all WPC pilots, though health plan roles and participation vary from pilot to pilot. Through WPC, pilots have developed relationships with their MCP partners to facilitate referrals and enable data sharing to improve care coordination and transitions for enrollees. Pilots with successful partnerships have implemented data sharing and referral agreements to engage and sustain engagement with health plans and ensure enrollees have coordinated, continuous care. DHCS envisioned WPC as a program that would bring counties and their MCPs together to address the needs of the most frequent users of the health care system, but many pilots see room for improvement in how they work with their MCPs to share, analyze, and make use of data to improve care for WPC enrollees. Mindful of the end of the WPC pilot in 2020, it is increasingly important for pilots and their MCPs to work together on how to sustain WPC services once the waiver ends.
- ***Hospitals, community health centers, and other community health providers:*** Community health partners play an important role in assisting WPC pilots in their mission. They can help identify individuals who might benefit from WPC services

and refer them to the program. If data sharing agreements are in place, hospitals can alert WPC staff when an enrollee comes to an emergency room (ER) or is admitted to the hospital.

Placer County, for example, partners with Sutter Health hospitals. The data sharing platform (PreManage from Collective Health Technologies) used by the county (discussed in more detail below) alerts the WPC team when an enrollee enters a Sutter ER (or any hospital in the nation using the same system—including many Bay Area hospitals and all the hospitals in Oregon). Once notified, the Placer WPC team dispatches a care coordinator, who can arrange for follow-up care and connections to needed services.

The Small County Collaborative, a pilot made up of two small counties (San Benito and Mariposa) that joined together to run a WPC program, demonstrates that smaller, more rural counties can also improve care coordination with hospital partners through person-to-person approaches. The WPC team sends their client list to the local hospital via secure email. When someone from the list shows up at the ER or is admitted, hospital staff call the WPC team. The hospital in Mariposa County flags WPC names in its electronic health record (EHR) system to identify WPC clients who present in the ER. This process helps to expedite communication and limit the number of missed connections with WPC enrollees.

- ***CBOs:*** CBOs are key to a successful WPC pilot. CBOs provide services to WPC enrollees that are integral to their overall health and well-being, and which counties may not provide directly. Examples of CBOs include housing providers, street outreach organizations, and other social service providers. Housing providers may also offer housing supportive services, which include connecting clients to affordable housing, employment training, and individual case management. While these services are funded through WPC, housing partners often also provide services that are complementary to WPC, but are not paid for by the program, thus enhancing coordination and expanding the services available to enrollees.

  Napa County, for example, credits its 86% WPC enrollee housing retention rate to housing supportive services provided by community-based partners. Whereas counties or cities may not have the capacity to provide such services, CBOs are experts in these areas. CBOs often share the same passion and "whatever it takes" approach as WPC county and city staff but can provide services outside of what can be a complex and bureaucratic system. Placer County also relies heavily on its housing partners to place WPC enrollees in housing and ensure that they have the services they need to remain housed and connected to health services. CBOs are generally more nimble than their county partners, particularly in their ability

to onboard staff, execute contracts, and/or locate and arrange housing placements. This expands the pilots' overall capacity to meet the needs of their target populations.

Though many pilots now feel confident about their partnerships, challenges remain:

- ***Ensuring there is no duplication of services:*** Understanding which services are covered by WPC can be complicated for partners that provide other Medi-Cal eligible services. Because WPC only covers specified services not eligible under other Medi-Cal programs, special attention to billing is needed, which is an issue especially for counties that also participate in Targeted Case Management (TCM) and Full Service Partnerships (FSPs), which provide wrap-around services similar to many WPC pilots.
- ***Staff turnover:*** Pilots work hard to train and communicate with CBOs on processes and available services to ensure coordination between various partners, but turnover within CBOs makes it difficult for some pilots to maintain consistent communication and workflows.

Data Sharing

The ability to share and act on enrollee health data is vital to WPC and has been described as a welcome "game changer" for those pilots that have successfully navigated the world of data sharing agreements. Not only did pilots need to work

City Model

The City of Sacramento faced a unique set of circumstances in setting up their WPC pilot. Unlike counties, the City of Sacramento has not traditionally played a role in the health care sector. WPC staff needed to cast an especially wide net in building partnerships and creating the culture of a city-centered WPC model. Staff described this as building a "purposeful connection between city and the health care world" as well as strengthening the relationships between health, housing and homeless service sectors.

For example, because WPC is only available to Medi-Cal enrollees, the city needed to stand up an "eligibility office," as counties are the entity responsible for Medi-Cal eligibility determinations. This new office cannot make eligibility determinations, but can check to see if an enrollee is Medi-Cal enrolled and help facilitate new enrollment and eligibility reverifications. They also needed to build out a health information infrastructure, which also didn't exist before WPC. These challenges, the City points out, has only led to particularly strong relationships between all the WPC partners.

through the legal requirements around how to share beneficiary data, they also had to invest in developing data infrastructure and help partners recognize opportunities created by more expansive data sharing.

Legal Frameworks

The Health Insurance Portability and Accountability Act (HIPAA), the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (42 CFR), and certain state laws, including an authorization specific to WPC in the California Welfare and Institutions Code (WIC 14184.60 (c)(5)), provide the legal framework for how personal health information (PHI) can be shared. In 2017, the California Office of Health Information Integrity released State Health Information Guidance (SHIG) on Sharing Behavioral Health Information that provided further direction specific to mental health and substance use records.

Despite the existence of these regulations pilots faced significant challenges in developing data sharing agreements such as Memorandums of Understanding (MOUs) and Business Associate Agreements (BAAs). Both external confusion (the SHIG was rereleased with edits), and internal confusion between pilot leads and county counsel, played and continue to play a role in preventing some data sharing agreements from moving forward. Many pilots also note that further guidance from DHCS would be helpful in clarifying data sharing expectations and allowances.

Data sharing agreements are dependent on the legal perspectives and comfort level of individual parties involved in the program. Every county's legal counsel, as well as every entity's legal department, has the latitude to interpret state and federal health information privacy statutes and regulations independently, requiring intensive negotiations to determine data sharing policies not just between county agencies but also between the county and every external partner. Pilots reported that it takes a significant investment of time and persistence for various legal departments to be comfortable moving forward with data sharing agreements that align with the vision of WPC.

"Instead of data sharing as the exception, it has become the norm."
– *Marin County Department of Health and Human Services*

Pilots also worked with legal counsel to develop beneficiary consent forms. A few pilots are focused on developing universal consent forms that allow them to share beneficiary data seamlessly between partners. The Alameda pilot, for example, developed a form based on extensive feedback from consumers and provider organizations. The form meets an eighth-grade reading level and addresses beneficiaries' concerns regarding sharing social and health data. Other pilots have created forms that allow information sharing on a case-by-case basis.

Consumer Engagement

Alameda County created the Consumer Fellowship and appointed nine individuals with direct lived experience in the public health, criminal justice, housing, and child welfare systems to help inform WPC innovations. The Fellows have contributed over 200 hours of input including critical observations and recommendations that foster development of culturally affirmative practices such as language used with the Universal Authorization form, housing flexible funding, and the Community Health Record.

Confusion around data sharing led to significant delays in pilot implementation, hindering the ability to coordinate care. Even two years into implementation, many pilots are still working through these issues. That said, pilots with finalized data sharing agreements have been able to move forward in setting up the infrastructure for securely and legally sharing enrollee information between partners.

Successful pilots set aside resources in their budgets that enabled them to hire outside legal experts and/or spend significant time working with internal and external partners to identify solutions and complete data sharing agreements. Even with willing and able partners and legal counsel to help guide the process, pilots pointed out that securing data sharing agreements took considerably more time than anticipated.

Data Sharing Technology

Many pilots used WPC funds to choose, create, or enhance data sharing platforms. Some pilots invested in extensive and comprehensive data sharing platforms, while others, often due to resource shortages or the nature of their data sharing agreements, pieced together more manual systems. Appendix C is a compilation of data sharing platforms and other methods pilots are using to share data across partners.

Pilots implemented a range of data sharing approaches, from sophisticated care management platforms that can match data access to an individual provider's permission settings to simple cloud-based forms and shared documents. Some pilots have achieved data sharing at scale, allowing population health approaches to data use,

while others continue to work on ensuring case-by-case data sharing and release of information forms.

Pilots also reported on the importance of achieving buy-in from their partners. For example, Mendocino County started talking with their partners early about purchasing a data sharing platform but ran into some challenges. Instead, they opted to start with a simple file sharing system (ShareFile) and use release of information forms to allow basic intake information to be shared among partners. After participating in this basic data sharing, partners began to see its value . With established buy-in, the pilot is now moving toward implementing a more robust care management platform.

On the other end of the spectrum is Placer County, which implemented PreManage, a data sharing platform that allows health plans and providers in the county's Adult System of Care (ASOC) to get real-time updates when an enrollee is admitted to, released from, or treated in an ER. Partners agreed to implement this product early, which enabled Placer County to set up a pilot in which care coordinators are easily able to track WPC enrollees, meet them quickly if they end up in an ED or inpatient hospitalization, and connect them to the appropriate care and resources. Placer County hopes to expand this system to connect with local Federally Qualified Health Centers (FQHCs).

Contra Costa County implemented Epic's EHR platform early on and worked to expand that platform beyond traditional physical health to incorporate behavioral, social, and community services. The pilot is now working with Epic to enhance the system for other customers across the country by sharing lessons learned and participating in collaborative groups. WPC pilots' use of these platforms has an impact beyond their pilots and counties, including shaping how technology companies are thinking about patient data and care—shifting towards a culture of collaboration and better-connected care across health and social service providers.

Data Uses

Pilots use data for care coordination and reporting outcomes, a required element for all WPC pilots. Though pilots understand the importance of data collection, there have been a few challenges to reporting:

- ***Collecting data:*** Collecting accurate and timely data for the required outcomes reporting is challenging. Pilots struggle to get the necessary data from partners to meet reporting requirements. Many of these pilots believe WPC is positively impacting their communities, but worry that without good data, this will progress will not be recognized
- ***Staff capacity:*** A few pilots note that they would have funded more staff positions for data collection and reporting had they known how time consuming and

challenging the process would be. Smaller pilots, especially ones with only one or two dedicated WPC staff, feel they do not have the capacity to both deliver services though WPC and collect and report data on the program.

- ***Measured metrics:*** Some pilots have concerns that the population-level metrics will not accurately show the successes of the pilot and argue that point-in-time measurements or enrollee-specific data may be better suited for the program. DHCS is aware of the data challenges pilots are experiencing and has demonstrated flexibility. For example, in some cases, pilots have been allowed to modify variant metrics based on availability of data.

Providing Coordinated Care

The heart of WPC is providing more coordinated services to enrollees. Most pilots credit the use of an interdisciplinary care coordination team, including community health workers (CHWs) and peer support specialists, for their ability to meet goals. Through WPC, pilots have invested time and resources in hiring and training CHWs and peer support specialists either at the county level or through contracted CBOs. Kings County, for example, contracts with a local organization that focuses on street outreach to assist in enrollment and retention. Ventura County invested time and resources into CHW training, including Mental Health First Aid, crisis prevention, and relapse awareness. They also provide real-time support of CHWs, including huddles, ongoing team member engagement, and quality improvement.

Workforce Development

Pilots have developed innovative methods for finding appropriate staff to fit the unique WPC roles and create career ladders. The Los Angeles pilot modified its traditional job descriptions to attract applicants with relevant "lived experience" (people who have experienced homelessness, incarceration, or are in recovery) and created a path for CHWs to grow into management roles. Challenges remain regarding workforce, however, as the time-limited nature of the pilot makes it difficult for pilots to hire staff for new or open positions (due to retirement, leave, or natural turnover) in the pilot's later years.

Using WPC funding, San Mateo County developed a multidisciplinary field-based care navigation team, Bridges to Wellness, comprised of social workers, care navigators, and nurse practitioners to work with the highest utilizers of health care services in the county. They report that the team has seen impressive results, including a 30% decrease in emergency room visits between 2016 and 2017 among the top tier of highest utilizers. Additional results show that among those enrollees surveyed, 80% report improved self-management skills and quality of life.

Alameda County improved processes for individuals experiencing a psychiatric emergency, putting a focus on ensuring warm handoffs to outpatient providers as part of its WPC work. They have been able to serve hundreds of WPC enrollees with this service. The pilot partnered with Alameda County Behavioral Health (ACBH) to integrate primary care and behavioral health data to identify severely mentally ill (SMI) consumers who had not visited a primary provider in over a year. ACBH staff funded by Alameda Care Connect supported the delivery of primary care psychiatry in the Federally Qualified Health Centers (FQHCs).

As part of San Bernardino County's WPC care coordination model, nurses visit client homes to help prevent readmissions. This might include teaching an enrollee to take their own blood pressure or improve diabetes self-care. They can spend much-needed time with clients to ensure they are connected to additional needed services.

Santa Cruz wanted to improve WPC case management in an integrated behavioral health setting. With WPC funding, they were able to hire new case management staff and a supervisor for medical clinics serving as the hubs for WPC services, which has improved overall care coordination for WPC enrollees.

Keeping individuals enrolled in Medi-Cal is key to WPC care coordination efforts. In Contra Costa County, social services staff embedded in WPC delivery services are able to access Medi-Cal eligibility systems to expedite administrative processes and ensure continued patient coverage. This creative workflow among partners supports patients while remaining restrictions to data sharing limit the ability of both partners to share full health and social services data.

In terms of challenges, some counties point to the limited number of providers in a given area as a hindrance to care coordination. In some cases, services, such as specialty medical or SUD services and supports just do not exist in the area. In other cases, counties (particularly smaller or more rural/suburban counties) reported having a sole source for some services. This creates capacity barriers as well as challenges when high-need, but difficult, clients and providers have a negative relationship. Providers may be "fed up" with a non-compliant or disruptive client, and clients may feel disrespected or like they will receive negative treatment if they return to a particular provider. Counties have reported that care coordination in these instances requires work to rebuild trust between providers and clients.

Housing Enrollees

Many pilots are focused on connecting WPC enrollees to housing. This is one of the most innovative aspects of the WPC program, and one of the most challenging for pilots to accomplish. While Medicaid funding cannot be used for purchasing or renting

housing units, it can be used for tenancy support services. WPC pilots provide these services in the following forms:

- Individual outreach and assessment;
- Tenant and landlord training and coaching;
- Partnering with CBOs to identify and secure housing for the target population; and
- Funds for a security deposit and first month's rent.

California has one of the worst housing shortages in the country and many of the WPC pilots are located in areas with the state's highest rents. The shortage of housing stock has been exacerbated by two years of destructive wild fires, which have both directly and indirectly impacted pilot counties. Despite these challenges, pilots are using WPC resources to house enrollees. Below are examples of successful pilot efforts:

"If you can fix someone's housing, it becomes easier to fix all their other problems."
– *Ventura County Health Care Agency*

- ***Housing vouchers:*** Marin County partnered with the local housing authority to ensure that a specified number of Section 8 vouchers are set aside specifically for WPC enrollees every year. The pilot agreed to provide intensive case management services through WPC to those receiving vouchers. This agreement enabled Marin to house individuals who might otherwise not have qualified for Section 8 housing because of their need for housing supportive services and has thus far resulted in housing for nearly one third of the county's chronically homeless individuals.
- ***Housing pools:*** The WPC program also allows pilots to develop county-wide flexible housing pools to structure funding to pay for housing services and supports, including payments for housing-related services for which Federal Financial Participation (FFP) is available. Housing pool funds can also be used for rental subsidies or investment in housing units, both of which are not eligible for FFP. WPC pilots can contribute to the housing pool and can seek contributions from partner and community entities.[v] WPC encourages pilots to develop housing pools with their partners to fund long-term housing costs such as ongoing rent or purchasing property. WPC funds can be used for supportive services to wrap around the housing purchased by these pools. Placer County developed a housing pool in partnership with Sutter Health and county Mental Health Services Act (MHSA) funds. Sutter contributed one million dollars to the pool initially, without requiring the pilot to first generate savings, but on the condition that the pilot would match their one million dollar investment. Between this investment and the county's match using MHSA funding (not WPC funding), the Placer WPC pilot purchased 14 housing units[vi] and

subsidizes eight more units in a project primarily funded by MHSA. Owning the units allows the pilots to quickly place WPC enrollees rather than working through other housing organizations with strict requirements individuals must meet to qualify for placement. Currently Placer is working to procure more housing after receiving an additional grant from Sutter Health and combining those funds with WPC savings.

- ***Coordinated entry system:*** Many pilots are working with their local Department of Housing and Urban Development (HUD)-required coordinated entry system to ensure WPC enrollees are referred into the system and assessed using the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) tool and considered for housing vouchers.
- ***Partnerships:*** A few pilots are contracting with community providers to place WPC enrollees in housing. In addition to its housing pool, Placer County contracts with Advocates for Mentally Ill Housing to find and place individuals in housing, thus eliminating longer county processing times and other bureaucratic challenges.

DHCS has demonstrated flexibility in the area of housing for WPC pilots. For example, Monterey County was able to do adjust its budget to provide security deposits, application fees, and first months' rent for enrollees experiencing homelessness.

Despite examples of success, lack of affordable housing stock in California and the length of time it can take to house members is by far one of the biggest ongoing challenges in WPC.

Sustaining Successes

WPC pilots are aware that the funding for the program is part of the state's 1115 waiver, and therefore will likely end on December 31, 2020. Because of this, pilots are starting to plan for 2021 and beyond. In 2019, pilots are focusing on evaluation, communications, and sustainability planning. All pilots point to WPC efforts that they believe will persist beyond the life of the pilot itself, specifically the relationships built, culture change, care coordination workflows, and data sharing agreements and platforms.

The key issue will be funding these services in the future. In early 2019, Alameda County launched a Sustainability Task Force to examine possible future funding streams. Pilots are looking to other state programs, such as the Health Homes Program, Targeted Case Management, and Specialty Mental Health services to sustain promising practices. Continued partnership with health plans and local hospitals is also part of the strategy around sustainability planning; health plans and hospitals have much to learn from WPC pilots.

Demonstrating value is important to pilots as they plan for sustainability. Sharing anecdotal evidence of individual quality of life improvements is one step; showing

return on investment and quantitative outcomes are much bigger steps. Thus far pilots have used local media – print and television – as well as podcasts, newsletters, and presentations to their county boards of supervisors to publicize how WPC has impacted their communities. More formally, UCLA, the official evaluators of the demonstration, will examine both qualitative and quantitative data elements to measure the efficacy of interventions and potential Medi-Cal savings. The WPC Learning Collaborative is also helping pilots collect and share their best practices and successes as well as helping them to think strategically about the sustainability of their programs post-2020.

Pilots point to both goodwill and political will built thus far as particularly helpful in considering sustaining promising practices developed through WPC. Pilots are entering a precarious stage of the demonstration, however. For example, because the demonstration officially ends in less than two years, staff positions that were labeled permanent are now considered limited/short term, which is a concern for current and future staff departures and makes hiring new staff difficult.

In the meantime, pilots are engaging with DHCS to determine next steps in expanding and improving services for the WPC populations.

About the Authors

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About the California Health Care Foundation

The **California Health Care Foundation (CHCF)** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient- centered health care system.

APPENDIX A: Pilot Geographic Areas and Lead Entities

Geographic Area	WPC Lead Entity
Alameda County	Health Care Services Agency
Contra Costa County	Health Services
Kern County	Kern Medical Center
Kings County	Human Services Agency
Los Angeles County	Department of Health Services
Marin County	Department of Health and Human Services
Mendocino County	Health and Human Services Agency
Monterey County	Health Department
Napa County	Health and Human Services
Orange County	Health Care Agency
Placer county	Health and Human Services Department
Riverside County	Riverside University Health System - Behavioral Health
Sacramento, City of	City of Sacramento
San Bernardino County	Arrowhead Regional Medical Center
San Diego County	Health and Human Services Agency
San Francisco City and County	Department of Public Health
San Joaquin County	Health Care Services Agency
San Mateo County	County Health System
Santa Clara County	Santa Clara Valley Health and Hospital System
Santa Cruz County	Health Services Agency
Shasta County	Health and Human Services Agency
Small County Collaborative- Mariposa and San Benito Counties	San Benito County Health and Human Services Agency and Mariposa County Health and Human Services Agency
Solano Counties	Health & Social Services
Sonoma County	Department of Health Services, Behavioral Health Division
Ventura County	Health Care Agency

Appendix B: WPC Metrics

Universal Metrics:

- Ambulatory Care - Emergency Department
- Comprehensive Care Plan
- Follow-Up After Hospitalization for Mental Health
- Initiation and Engagement of Alcohol & Other Drug Dependence
- Inpatient Utilization

Variant Metrics:

Housing/Homelessness

Metrics	Pilots Reporting
Common Assessment for Coordinated Entry: Universal Assessment Tool	San Francisco
Completion of Universal Assessment Tool with Homeless Individuals: Variant Universal Assessment with Administrative Data	San Francisco
Encampment Days to Placement Days	San Francisco
Housing Supportive Services	Alameda, Kern, Marin, Monterey, Orange, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Cruz, Small County Collaborative, Sonoma, Ventura
Less Restrictive & More Independent Housing	Alameda
Number of days in Independent Living or Permanent Supportive Housing	Orange
Number of Homeless Days	Orange
Other assessment for Homeless Self-Reporting	San Francisco
Percent of New Clients who were Homeless or in Shelter become Permanently Housed within 3 Months of Enrolling in the Project	San Diego
Permanent Housing	Alameda, Los Angeles, Mendocino, Napa, Riverside, Sacramento, San Diego, San Francisco, Shasta, Solano
Supportive Housing	Alameda, Riverside, San Francisco, Santa Clara, Santa Cruz, Solano

Case and Care Management and Transitions/Referrals

Metrics	Pilots Reporting
12 Months Coordinated Case Management	Santa Cruz
Assignment of Care Coordinator	San Mateo
Average Number of Monthly Contacts by WPC Pilot Case Manager Per WPC Participant	Shasta
Care Coordination Assignment	Alameda
Care Team Meetings Established and Held	Sonoma
Coordinated Case Management	Monterey
Members Linked to Case Management	Orange
Percent of Referrals Resulting in Linkage to Services from County Behavioral Health	Orange
Timely Case Management Enrollment	Santa Cruz
Timely Case Management: 30 day Follow Up After Discharge	Monterey

Health Outcomes

Metrics	Pilots Reporting
Adult Body Mass Index (BMI) Assessment (HEDIS)	Kern
All Cause Readmission	Kern, Monterey, Napa Orange, Placer, Sacramento, San Bernardino, San Francisco, San Mateo, Santa Clara, Small County Collaborative, Solano, Sonoma
Avoidable Hospitalization	Monterey
Comprehensive Diabetes Care	Kern, Kings, Mendocino, Monterey, Orange, San Bernardino, San Joaquin, San Mateo, Santa Cruz, Shasta, Ventura
Control Blood Pressure	Alameda, Kern, Mendocino, Monterey, San Bernardino
Depression Remission at 12 Months	Alameda, Contra Costa, Kern, Marin, Monterey, Orange, Placer, Riverside, San Bernardino, San Diego, Santa Clara, Santa Cruz, Small County Collaborative, Shasta, Solano, Ventura

Metrics	Pilots Reporting
Disease Prevention and Self-Management: Substance Abuse Prevention	Santa Cruz
Gains in Patient Activation Measure (PAM) Scores at 12 Months	San Bernardino
Incarcerations	Kings, LA, Riverside, San Francisco, San Joaquin, Sonoma
Increase PCP Office Visit	Orange
Major Depressive Disorder - Suicide Risk Assessment	Alameda, Contra Costa, Kern, Kings, Los Angeles, Marin, Mendocino, Monterey, Napa, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Small County Collaborative, Shasta, Solano, Sonoma, Ventura
Mental Health Follow-Up to PES Visit within 7/30 Days of Discharge	Alameda
Mental Health Unit 30 Day Readmission	Monterey
Number Hospital Days Clients in Psychiatric Hospital During First 12 Months of Enrollment Compared to 12 Months Immediately Prior to Enrollment	San Diego
Number of Days Psychiatrically Hospitalized	Orange
Number of Hospital Days Clients in 2nd, 3rd or 4th Year in Pilot are in Psychiatric Hospital Compared to Prior year	San Diego
Overall Beneficiary Health	Contra Costa, Kern, Marin, Napa, Riverside, Sacramento, San Bernardino
Percent of Clients Seen by PCP within 60 Days of Enrollment	San Diego
Percent Received Medical Respite services and Health Improvement Annually	Placer
Percentage of Participants who Receive Recuperative Care Services who are Not Readmitted to the ED or as an Inpatient within 90 Days of Discharge	Ventura

Metrics	Pilots Reporting
Percentage of Participants with at Least Six Encounters with a Clinical Social Worker During the Project Year	Ventura
Primary Care Provider (PCP) Visit within 30 Days of Enrollment	Marin
Recuperative Care Readmissions	Ventura
Rehospitalization for Mental Health	Santa Cruz
SBIRT Substance Abuse and Mental Health Universal Screening	Contra Costa, Kern, Monterey
Tobacco Assessment and Counseling	Monterey
Tuberculosis Clearance	San Francisco
Wellness Lifestyle Attendance	Kern

Administrative

Metrics	Pilots Reporting
Beneficiary Enrollment and Assessment in WPC	Santa Clara
Complete and Accurate Data for the Month Entered into the Data System by the 10th of the Month Following the Reporting Period by the Contractor.	San Diego
Document Transition to PCP	Monterey
Engagement Measure	Sacramento
Medical List from Hospital	Santa Cruz
Medication List	Monterey
Medication Reconciliation 30 Days of Enrollment	Kern
Number of Unique Individuals who had Updated Information Pushed into the San Joaquin County Health Information Exchange	San Joaquin
Timely Documentation from Hospital to Clinic	Santa Cruz
WPC Monthly Meeting	Los Angeles, Mendocino

Appendix C: WPC Data Sharing Platforms

Type	Examples
Electronic Health Records/Population Health Management	• PreManage • EPIC • IMB Software (ConnectWell SD, Master Person Index) • Social Solutions (Efforts to Outcomes- ETO, case management software) • Forward Health • CrossTx • eBHS • VerticalChange
Data Bases	• Microsoft Access
Cloud-Based File Sharing	• Google G Suite • SalesForce • Citrix Sharefile • Exym • Box

ENDNOTES:

[i] The WPC Learning Collaborative is a requirement of the WPC program, as outlined by the Medi-Cal 2020 Special Terms and Conditions, which state "The WPC Pilot Lead Entity shall agree to help develop and participate in regular learning collaboratives to share best practices among Pilot entities." Harbage Consulting and the Center for Health Care Strategies run the Learning Collaborative on behalf of the state. Pilots meet in-person twice a year and participate virtually through conference calls and webinars.

[ii] The Medi-Cal 2020 waiver was approved on December 30th, 2015 and expires on December 31st, 2020. The first 18 WCP Pilots were approved for implementation on January 1st 2017, and an additional seven pilots were approved for implementation on July 1st, 2017.

[iii] WPC Timeline (*PY* is Program Year)

PY 1: January 1-June 30, 2017
PY 2: July 1-December 31, 2017
PY 3: January 1-December 31, 2018
PY 4: January 1- December 31, 2019
PY 5: January 1-December 31, 2020

[iv] Per the WPC applications, high utilizers is the term used by many pilots for Medi-Cal enrollees who are frequent utilizers of services.

[v] Subject to applicable provisions of Section 1903(w) of the Social Security Act and 42 C.F.R. Part 433, subpart B.

[vi] Placer County defines a 'housing unit' as a bedroom. Thus far, they have purchased two homes, one with six bedrooms and one with eight bedrooms, and are subsidizing eight bedrooms in a 21 bedroom property.