Interim Evaluation of California's Whole Person Care (WPC) Program

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Interim Evaluation of California's Whole Person Care (WPC) Program

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Chapter 1: Executive Summary

WPC Program Overview

The California Department of Health Care Services (DHCS) implemented a Section 1115 Medicaid Waiver called "Medi-Cal 2020," which started on January 1, 2016 and is scheduled to end on December 31, 2020. Under this Waiver, DHCS implemented the Whole Person Care (WPC) program for high-risk, high-utilizing enrollees who have a complex profile and are high need. A total of 25 Pilots, representing the majority of counties in California, implemented WPC starting in January 2017 in two phases. The overarching goal of WPC was to improve health and wellbeing by coordinating care across spheres of care delivery including health, behavioral health, and social services. Pilots consisted of 27 Lead Entities, a county organization, city or consortium of counties with expertise and resources to implement the program that partnered with other county organizations and community providers to deliver services or otherwise help implement the program. Pilots were required to target one or more of the following six populations identified by DHCS: (1) high utilizers of avoidable emergency department, hospitals, or nursing facilities (high utilizers); (2) individuals with two or more chronic physical conditions (chronic physical conditions); (3) individuals with severe mental illness and/or substance use disorders (SMI/SUD); (4) individuals experiencing homelessness (homeless); (5) individuals at-risk-of-homelessness; and (6) individuals recently released from institutions, including jail or prison (justice-involved). Pilots defined individual or bundles of services provided in their applications and were paid per-member, per-month for bundles and fee-for-service for individual services (e.g., outreach and sobering centers). Pilots reported on pre-specified universal metrics and chose additional variant metrics. Some Pilots selected pay-for-outcome incentives for some metrics.

Evaluation Methods

The UCLA Center for Health Policy Research was selected to evaluate WPC and developed a conceptual framework and evaluation questions to conduct a rigorous, state-wide, mixed-methods assessment of the program. UCLA used all available data for the evaluation, including 25 Pilot applications, Pilot-reported universal and variant metrics, monthly enrollment and utilization reports, bi-annual narrative reports, and Medi-Cal enrollment and claims data. UCLA also conducted interim surveys of 27 Lead Entities and 227 involved partners, follow-up interviews with LEs and frontline staff, and an additional interview with Plumas (Small County Whole Person Care Collaborative), which dropped WPC in September 2018. UCLA used the qualitative data sources to examine the infrastructure developed by Pilots for WPC, implementation processes, and services delivered. UCLA used Pilot-reported metrics and Medi-

Cal data to determine whether WPC led to better care and better health within the first three years of WPC. Analyses of Medi-Cal data included comparison of selected WPC metrics before and after WPC implementation for WPC enrollees and a control group of Medi-Cal enrollees with similar characteristics.

Results

Motivation for WPC Participation

Available data showed that Pilots were highly motivated to participate in WPC primarily because WPC fit their strategic priorities, was synergistic with other concurrent initiatives, and was considered an important goal of the organization. This was likely to have played a significant part in successful implementation of the program. These conclusions were supported by the following specific findings:

- In interviews, Pilots indicated that their participation in WPC was motivated by the objectives of (1) reducing silos, (2) improving "value" of care, and (3) increasing access to patient-centered care.
- In surveys, Lead Entities rated (on a scale of 0: not at all important and 10: very important) their highest motivators as: getting necessary services for enrollees (average of 9.4 of 10), improving integration of care for enrollees with multiple needs (9.4), and improving quality of care (9.2). Partners rated improving integration of care (9.4) as their highest motivator.
- Many Pilots (17 of 27) reported participating in other concurrent initiatives; those most compatible with WPC were the Medi-Cal Health Homes Program and the Drug Medi-Cal Waiver Program.

Structure of WPC Pilots

Available data showed that Pilots chose Lead Entities (LEs) that had the leadership and administrative capacity to implement WPC. Partnership efforts appeared to have largely succeeded based on relatively high ratings of buy-in from and increases in interactions with partners. Successes were achieved through continuous efforts to developing new and maintaining existing partnerships across the spectrum of internal and external partners. These conclusions were supported by the following specific findings:

- LEs included county health and health services agencies (15 of 27), healthcare systems (8), behavioral health departments (3), and a city municipality (1). Pilots reported an average of 19 partners per Pilot and a collective total of 507 across all Pilots. Over half of

partners (57%) were community-based organizations. In interviews, Pilots described selecting partners to help strengthen pre-existing relationships, complement other initiatives, and/or help address gaps in care for target populations.

- In surveys, Pilots reported that 47% were actively participating in overall decision making and highest partner buy-in from housing providers and health plans for data sharing and care coordination activities (average rating of 7.7 and 7.6, respectively, on a scale of 0: very low to 10: very high). The extent to which partners were actively involved in implementing WPC varied across Pilots and by type of partner.
- In interviews, LEs identified staff turnover within partner organizations and limited partner interest in WPC as barriers to partner buy-in and identified constant nurturing of inter-organizational relationships as critical for fostering organizational buy-in to the project.
- In surveys, partners generally rated (on a scale of 0: not at all to 10: very much) WPC as effective at improving how partners worked together on collaborative projects (average of 7.1 of 10), managing care of high-risk, high-utilizing enrollees (7.2), and improving coordination of health and social services within the community (7.2).

Health Information Technology and Data Sharing Infrastructure

Available data showed that Pilots began WPC with different degrees of data sharing infrastructure but collectively made progress in increasing their capacity, though gaps in ability to share data with internal and external partners remained. Pilots who already had a common data sharing platform often faced fewer initial barriers to implementation. Despite gaps in data infrastructure, Pilots found ways to share the most important data needed for outreach and enrollment, monitoring partner performance, and quality improvement activities. One specific accomplishment was establishing a case management tool under WPC, which was rare prior to WPC. These conclusions were supported by the following specific findings:

- In interviews, many Pilots indicated having established or acquired tools to track enrollees, record notes during interactions with enrollees, and indicate services delivered from anywhere and in real-time.
- HIEs were a common platform for sharing data. In surveys, 13 out of 27 Pilots participated in an HIE; with seven having done so during WPC. The majority of HIEs were centralized at a third-party organization and many HIEs had capacity to notify primary care providers or care coordinators of discharges or ED visits (12) and aggregate data for reporting (8).

- In surveys, Pilots reported that improvements in data sharing allowed them to identify eligible Medi-Cal beneficiaries (23 of 27), identify target populations (21), and track performance of providers (20).
- In narrative reports, the three most common data sharing and reporting challenges included (a) inability to implement data sharing systems and/or integrate data as intended (identified by 20 of 25), (b) issues with data reporting (18), and (c) legal and cultural barriers to data sharing such as risk aversion and differing interpretations of laws and regulations (16). Pilots described efforts to address these challenges by developing a new software platform and/or repository (25), sharing data across multiple systems (24), and implementing data sharing agreements (e.g., MOUs, BAAs) and consents with WPC partners (21).

Identification, Enrollment, and Engagement of Eligible Medi-Cal Beneficiaries

Pilot approaches to identification of eligible enrollees matched their target populations and were designed to find prospective enrollees where they lived and gathered, including streets and shelters. This was an important strategy, particularly for Pilots that targeted the transient homeless populations who could not be found with traditional modes of communication and required intensive efforts to develop rapport and trust in order to enroll them in WPC or provide limited, but necessary services. Following enrollment, similar multimodal approaches to communication were required to engage and retain enrollees and maintain trust. These efforts led to significant growth in WPC enrollment starting in PY 2 and PY 3 with limited churn and successful retention of enrollees. These conclusions were supported by the following specific findings:

- Between January 1, 2017 and December 2018, Pilots collectively enrolled a cumulative total of 108,667 unique individuals. Although Pilots identified Medi-Cal churn as a barrier to program enrollment in interviews, there was limited churn in Pilot-reported enrollment, with nearly half (49%) of enrollees staying continuously enrolled and only 7% of enrollees enrolling and disenrolling multiple times.
- In interviews, Pilots reported using various strategies to identify prospective WPC enrollees, including the use of administrative and electronic medical record data, referrals from diverse sources, warm hand-offs from health and social service partners, street outreach, and self-referrals. Once enrolled, Pilots engaged enrollees in their care and retained them through individual in-person meetings. Pilots reported that assignment to a dedicated care coordinator who could establish rapport and trust with enrollees was critical for working with WPC target populations.

- In narrative reports, the three challenges most commonly reported by Pilots in identifying, enrolling, and engaging eligible beneficiaries included (a) maintaining enrollee engagement after initial enrollment (identified by 12 of 25), (b) enrolling eligible individuals (11), and (c) addressing eligibility gaps in Medi-Cal enrollment, i.e., Medi-Cal churn (10). Pilots described efforts to address these challenges by establishing referral pathways into the WPC program (13), developing protocols for more quickly identifying and assessing eligibility of prospective enrollees (13), and proactively preventing Medi-Cal disenrollment by actively monitoring eligibility and renewal dates with data (8).

WPC Services Offered and Delivered

Consistent with the goals of WPC, all Pilots offered care coordination and housing services. Assessment of services delivered to enrollees indicated they were frequently aligned with the needs of the target populations. Variations in attribution of enrollees to a given target population and bundling of services was a barrier to an accurate assessment of which patients received specific WPC services. Nevertheless, assessment of payments by target population was a reasonable proxy for the intensity of service use and showed higher intensity of services to the most challenging enrollees, such as the SMI/SUD group. These conclusions were supported by the following specific findings:

- Pilots reported on WPC services delivered to enrollees in their enrollment and utilization reports, primarily using bundles that often varied by services included in each bundle. UCLA identified eight categories of service (described below) using this data and calculated the maximum number of enrollees who may have received a service. Data on whether an enrollee received all or some of the services as part of a bundle were not available for evaluation. Therefore, use of some services may be overestimated.
- All 27 Pilots offered care coordination and housing support services and many Pilots provided peers with similar lived experience to provide a range of services (20), benefit support (19), and outreach services (15). Fewer Pilots offered medical respite (11), sobering centers (7), and employment assistance (5).
- The most commonly received services were estimated to be care coordination (77%) and housing support services (69%), frequently as part of service bundles. These latter services focused on helping enrollees live in the least restrictive community-based setting appropriate to their needs and often included financial assistance to support housing-related needs.
- Services provided by peers were provided to 46% of all enrollees. The use of peers to provide services and support to enrollees was meant to improve enrollee engagement.

- Most WPC enrollees (69%) received benefit support, including 72% of high utilizers. Support was provided for benefits including Medi-Cal, CalFresh, or transportation to appointments.
- Nearly half of WPC enrollees (45%) received employment assistance. Employment assistance was intended to support enrollees with developing skills and connections that would improve their chances of obtaining employment.
- About 5% of enrollees received sobering center care and 3% received medical respite care. Populations receiving sobering center services were more often SMI/SUD (24%) and medical respite were more often homeless (5%). These services offered alternatives to EDs, hospitals, or jails. Under WPC, sobering center care services could be offered to eligible populations not enrolled in the program and were provided to 16% of this group.

WPC Care Coordination

Available evidence indicated that Pilots had different approaches to infrastructure development and delivery of care coordination services with varying results. By the end of PY 3, Pilots had successfully formed care coordination teams, shared critical data across sectors despite multiple challenges, standardized protocols to ensure consistency in care coordination activities to some degree, and at times incorporated financial incentives to promote high level of performance from external partners. Evidence also indicated that Pilots anticipated making further progress in addressing tenacious problems and how these problems could be addressed. These conclusions were supported by the following specific findings:

- UCLA developed a conceptual framework for assessing care coordination under WPC and included elements of infrastructure needed and the processes to be followed to successfully deliver care coordination. Care coordination efforts were examined by using interview data completed by early 2019.
- Among infrastructure needs, 20 of 26 Pilots included peers with similar lived experience to their target populations. Another 22 Pilots had comprehensive care plans stored in an electronic database; 11 used a single integrated data system. Sixteen Pilots established systematic protocols for medical, behavioral health, and social service referrals and 17 reported standardized protocols for monitoring and following up on enrollees who received care. All Pilots were paid for care coordination under PMPM bundles. Twenty of 26 Pilots used external partners to deliver all or some care coordination services and 14 Pilots provided financial incentives to these partners to foster buy-in and accountability. All Pilots (26) required that care coordinators contact enrollees more than once a month. Care coordinators were expected to use in-person meetings, phone

calls, text messages, and emails to meet enrollee needs/preferences where they lived or congregated.

- Among processes followed, all Pilots (26 of 26) used comprehensive assessments and screening tools that addressed patients' medical, behavioral health, and social needs and most recognized the importance of regular updates. All Pilots (26) used active referral strategies (e.g., making and attending appointments, transportation assistance, and follow-ups), and noted improvements in care coordination and continuity of care because of WPC. All Pilots' care coordination teams used multiple communication modes to engage enrollees in their care and retain them in WPC. Care coordination teams communicated through the EHR and other data systems to keep track of enrollee data.
- In narrative reports, the three challenges most commonly reported by Pilots in care coordination included (a) limited availability and/or accessibility of services being coordinated, particularly housing (24 of 25), (b) engaging appropriate interdisciplinary partners in program implementation (23), and (c) staffing issues (16). Pilots described efforts to address these challenges by implementing new or improved care coordination delivery services (25), establishing partnerships to overcome silos (22), and using data systems to support care coordination activities (18).

WPC Performance Improvement and Program Monitoring

Pilots were required to engage in regular performance improvement activities and submit bi-annual Plan-Do-Study-Act (PDSA) reports documenting Pilot-led efforts to improve metric performance. Evidence indicated a significant number of PDSAs were conducted, which were aligned with areas of WPC implementation, such as care coordination, and outcomes, such as hospitalizations. Diversity in Pilots' needs such as their focus on different target populations, differences in geographic/local contexts, and their progress in data sharing infrastructure. These differences made it challenging for Pilots to effectively learn from one another and establish program-wide "best practices". Other forms of performance improvement activities of Pilots included conducting informal or formal assessments to measure impact, identifying solutions to challenges, justifying level of effort, reallocating funds, and determining which elements to sustain after 2020.

Enrollee Demographics, Health Status, and Prior Health Care Utilization

Findings showed that Pilots captured very high need and high cost Medi-Cal patients which was consistent with overarching goals of WPC. Evidence showed that Pilots primarily enrolled Medi-Cal beneficiaries who were frequently men, 50-64 years old, White, English speaking, and enrolled in managed care. These beneficiaries had high rates of hypertension, substance use

disorders, and mental health conditions. WPC enrollees also had high rates of service use, particularly SUD services and ED visits and an increase in these rates over time prior to WPC enrollment. These conclusions were supported by the following specific findings:

- Enrollee demographics were examined using a subset of WPC enrollees who were enrolled in Medi-Cal (104,691 enrollees). Health status and pre-WPC health utilization of enrollees was examined for a smaller subset of these enrollees who used services under Medi-Cal during this timeframe (96,868 enrollees).
- Examining demographics of these WPC enrollees showed that they were most frequently ages 50-64 years old (35%), male (55%), White (28%), spoke English as their primary language (87%), and had been in Medi-Cal managed care prior to WPC enrollment (57%).
- WPC enrollees had high rates of mental health conditions such as depression (29%), anxiety (24%), schizophrenia and psychotic disorders (23%); substance use disorders, such as drug (26%) and alcohol use disorders (17%); and chronic conditions, such as hypertension (33%).
- Examination of pre-WPC ambulatory care visits and services, ED utilization, and inpatient hospitalizations reflect a historically upward trend. From 19-24 months prior to WPC enrollment to 1-6 months prior to WPC enrollment, primary care visits, ED visits and hospitalizations increased from 363 to 436 visits, 153 to 215 visits and 52 to 75 stays per 1,000 Medi-Cal member months, respectively. These trends suggest appropriate identification and enrollment of high utilizer enrollees by Pilots.

Better Care

Overall, substantial evidence indicated that Pilots successfully provided better care to WPC enrollees based on improved rates of follow-up after hospitalization for mental illness, initiation and engagement in alcohol and other drug dependence treatment, timely provision of comprehensive care plans, and suicide risk assessments. These findings were based on analyses of Medi-Cal data when possible and Pilot-reported data if not. Using the former, UCLA replicated metrics 2.3, follow-up after hospitalization for mental illness, and 2.4, initiation and engagement of alcohol and other drug dependence treatment, and examined unadjusted trends before and after each enrollee's date of enrollment into WPC. Trends in these rates were analyzed overall, by target population, and whether Pilots selected the metric for a pay-for-outcome incentive. Difference-in-difference (DD) methodology was used to compare adjusted rates between WPC enrollees and a control group of Medi-Cal enrollees before and during WPC enrollment. The control group was selected using WPC enrollee demographics, health conditions, and service utilization. Findings from these analyses further supported that WPC Pilots provided better care to WPC enrollees. Pilots-reported data were examined to

assess receipt of a comprehensive care plan within 30 days and the percent of enrollees with a diagnosis of major depressive disorder who had a suicide risk assessment. These data showed a complex pattern but multiple improvements in care delivery under WPC. The following specific findings support the conclusion that Pilots successfully provided better care to WPC enrollees:

- Data showed that unadjusted rates of follow-up after hospitalization for mental illness at 7 and 30 days and the rates of initiation and engagement of alcohol and other drug dependence treatment increased for those enrolled during WPC (WPC Years 1 and 2) compared to before enrollment (Pre-WPC Years 1 and 2) for both PY 2 and PY 3 enrollees (see Chapter 11: Better Care, Exhibit 119 and Exhibit 129).
- Adjusted comparison of WPC enrollees and the control group showed a significant increase in follow-up after hospitalization for mental illness at 7 and 30 days and initiation and engagement of alcohol and other drug dependence treatment. In addition, these increases were significantly greater for WPC enrollees than the control group (see Chapter 11: Better Care, Exhibit 139).
- The number of WPC enrollees that received a comprehensive care plan within 30 days of enrollment increased from 12% to 27% from PY 2 to PY 3.
- The rates of suicide risk assessments among enrollees with a diagnosis of major depressive disorder increased from 10% in baseline to 19% and 21% in PY 2 and PY 3.

Better Health

The evidence related to better health showed a complex picture of progress under WPC. As described earlier, examination of pre-WPC ambulatory care visits and services, ED utilization, and inpatient hospitalizations reflect a historically upward trend for these enrollees. Pilots' efforts to successfully identify and enroll high utilizers was reflected in metrics that measured ED visits, hospitalizations, and all-cause readmission which showed that these rates were steeply increasing prior to WPC enrollment, along with some increase during in the first year of WPC enrollment, but were declining in the second year of WPC.

Improvement was noted in metrics such as beneficiary self-reported overall and emotional health, controlled blood pressure, and diabetes control. These findings were based on analyses of Medi-Cal data when possible and Pilot-reported data if not. Using the former, UCLA replicated metrics 2.1, emergency department visits, 2.2, inpatient utilization, and 3.1.1, all-cause readmissions using Medi-Cal claims data. The same analyses as reported in Better Care were performed using Medi-Cal and Pilot-reported data. Pilot-reported metrics included rates of jail incarcerations, overall beneficiary health, blood pressure control, diabetes control, and depression remission. These conclusions were supported by the following specific findings:

- Among PY 2 enrollees, who enrolled during 2017, unadjusted rates of ED visits showed an ongoing increase in utilization from 169 to 214 prior to WPC enrollment (Pre-WPC Years 1 and 2), followed by a lesser increase (216) in the first year of WPC enrollment (WPC Year 1) and decrease to 181 in the second year of enrollment (WPC Year 2). A similar trend was observed for hospitalization and all-cause readmission rates (see Chapter 12: Better Health, Exhibit 148, Exhibit 153, and Exhibit 158. Among PY 3 enrollees, who enrolled during 2018, unadjusted rates of ED visits slightly declined in the year after enrollment (WPC Year 1). For hospitalization and all-cause readmissions, rates increased after enrollment for those newly enrolled during PY 3.
- Using difference-in-difference methodology to compare the adjusted trends in rates of ED visits and hospitalizations between WPC Pilot enrollees and a control group of Medi-Cal enrollees did not show a significant change for either group in ED visit rates and a significant increase in hospitalizations for WPC enrollees compared to the control group (see Chapter 12: Better Health, Exhibit 163). However, assessment of the rates from the first to the second years of WPC enrollment showed a decrease in both the ED and hospitalization rates. Assessing the change in ED visit rates during the two years after WPC enrollment indicated that this rate decreased by 19% for WPC enrollees and 8% for the control group, a significantly larger decrease for the WPC enrollees.
- UCLA also constructed an alternative way to assess the impact of WPC to show the proportion of people in the WPC population who ever had an ED visit or hospitalization. The results showed that fewer WPC enrollees had any ED visit or hospitalization during WPC than the control group (see Chapter 12: Better Health, Exhibit 163).
- Comparing the adjusted trends in rates of all-cause readmissions overall and among Pilots that selected to report on this variant metric pre- and during WPC did not show a reduction in either group. Yet, the rates of all-cause readmissions did decline from WPC Year 1 to WPC Year 2 and this decline was greater among WPC enrollees compared to the control group.
- WPC Pilots reported improvements in the percent of enrollees incarcerated (18% to 20%), being in excellent or very good overall (8% to 22%) or emotional health (15% to 22%), with controlled blood pressure among 18 to 59 year olds (36% to 65%), and controlled HbA1c among enrollees with diabetes (52% to 58%), from baseline to during WPC respectively.

Homeless WPC Enrollee Services and Outcomes

Nearly half of WPC enrollees were homeless across all target populations and regardless of Pilots' focus. The profile and living conditions of homeless enrollees necessitated strategic and innovative approaches in outreach and delivering services to homeless populations. The

assessment of outcomes after two years of WPC enrollment showed early successes in delivery of housing services and receipt of supportive housing but also challenges in retaining permanent housing. Analyses of Medi-Cal Data also indicated promising reductions in ED visits and hospitalization. A major issue in addressing housing challenges for homeless enrollees was lack of funding to directly provide housing and lack of adequate housing supply. Some Pilots leveraged other funding sources and worked with external partners to mitigate these challenges. Overall, substantial evidence was provided to show delivery of housing services and potential success in reducing ED utilization. These conclusions were supported by the following specific findings:

- In interviews and narrative reports, Pilots used in-person communication where homeless patients gathered that promoted trust building, a specific homeless tracking system, and specialized housing coordinators with lived experience as part of the multidisciplinary care team (17 of 26). In partner surveys, internal and external housing partners rated (on a scale of 0: very low to 10: very high) buy-in for data sharing and care coordination highly (average of 7.7 of 10). Pilots also leveraged non-WPC funding sources within their County to assist enrollees with payments by establishing a flexible housing pool, partnering with local community housing resources, and utilizing federal and other grants.
- Pilots reported 46,298 total in cumulative enrollment of homeless enrollees by December 2018. Based on Medi-Cal data, homeless enrollees had higher rates of SMIs, such as schizophrenia and psychotic disorders (27% vs. 14%) and SUDs, such as drug use disorders (37% vs. 19%). They also had higher rates of ED visits than not homeless enrollees. Among PY 2 enrollees, the rates declined more for homeless enrollees by 54 visits in WPC Year 2 than not homeless enrollees (17 fewer visits per 1,000). A similar pattern was observed for hospitalization rates.
- Pilot-reported metrics showed an increase from PY 2 (baseline year for housing metrics) to PY 3 in proportion of homeless enrollees who received housing services (from 58.3% to 66.8%), with 443 and 2,670 enrollees receiving services in PY 2 and PY 3, respectively. Overall rates of success in receiving supportive housing after being referred decline from 42.3% to 13.8%. This decline was due in part to significant increases in enrollment during PY 3 and the corresponding increase of demand for supportive housing from new enrollees. In total, 399 (PY 2) and 1,104 (PY 3) enrollees received supportive housing. Permanent housing rates remained high at 99% in PY 2 and 94% in PY 3, with the small decline largely due to limited reporting by some Pilots in PY 2. In total, 2,041 (PY 2) and 4,704 (PY 3) enrollees were permanently housed. Pay for outcome incentives were associated with better metric values in PY 3 among Pilots with these incentives.

- Common housing challenges included coordinating care and linking enrollees to housing services, collecting data to measure outcomes, and a lack of affordable housing. The latter was viewed as a systemic barrier. Solutions included partnerships with local organizations to obtain affordable housing for enrollees.
- In surveys, Pilots and external partners rated (on a scale of 0: not effective to 10: extremely effective) their efforts as effective in increasing client/patient access to housing and supportive services (average of 7.2 and 6.8 of 10, respectively).

Sustainability

The final evaluation report will assess the role of WPC in reducing costs for WPC enrollees and Medi-Cal overall and the extent to which care coordination and partnerships were sustained after the end of WPC. Given the level of effort to date, limited information was provided by the Pilots as they shared their early thoughts on sustainability of WPC. Data implied that sustainability of data sharing infrastructure or meaningful care coordination processes were a priority and Pilots were hoping to demonstrate value in order to secure other funding sources beyond 2020. These conclusions were supported by the following specific findings:

- In interviews, Pilots most often noted their intentions to sustain (1) key processes and infrastructure for care coordination, (2) established partnerships, and (3) data sharing infrastructure and activities.
- 22 of 25 Pilots had participated in informal discussions on sustainability within the Lead Entity.
- Availability of funding and evidence of positive and measurable impact were important elements for sustainability of WPC after the end of the program.

Conclusions and Next Steps

This interim report presents the findings of the first three years of the comprehensive state-wide evaluation of WPC in California. The report provided extensive evidence that WPC Pilots developed infrastructure and followed deliberate processes to implement the program and deliver services in order to promote better care, better health, and reduce costs. While the evidence of success for specific infrastructure and process elements was variable, independent analyses of Medi-Cal data showed success in better care and potential improvements in health to be further assessed at the end WPC. The evaluation confirmed success of the program in enrolling high-risk, high-utilizing Medi-Cal beneficiaries, many of whom had ongoing medical and psychosocial conditions and were complex prior to enrollment. These enrollees required intensive care coordination and service needs. The progress of the Pilots in the interim

reflected the challenges of historical gaps in management of these patients and difficulties in addressing underlying social determinants of health, particularly for highly complex patients such as those with insecure housing. Addressing these substantial challenges requires time, resources, and deliberate effort. The final WPC evaluation will include an assessment of each target population by Pilot and compare the differences in the "package of interventions" of the various Pilots to potentially identify services that improve outcomes. Further, the final WPC evaluation report will including an assessment of all five years of WPC as well as analyses of lower costs and likelihood of sustainable elements of WPC.

Chapter 2: Introduction

WPC Program

The California Department of Health Care Services (DHCS) implemented a Section 1115 Medicaid Waiver called "Medi-Cal 2020" that started on January 1, 2016 and is scheduled to end on December 31, 2020. Under this Waiver, DHCS implemented the Whole Person Care (WPC) program to address the challenges in Medi-Cal associated with high-risk, high-utilizing enrollees who have a complex profile and are high need.

WPC Goals

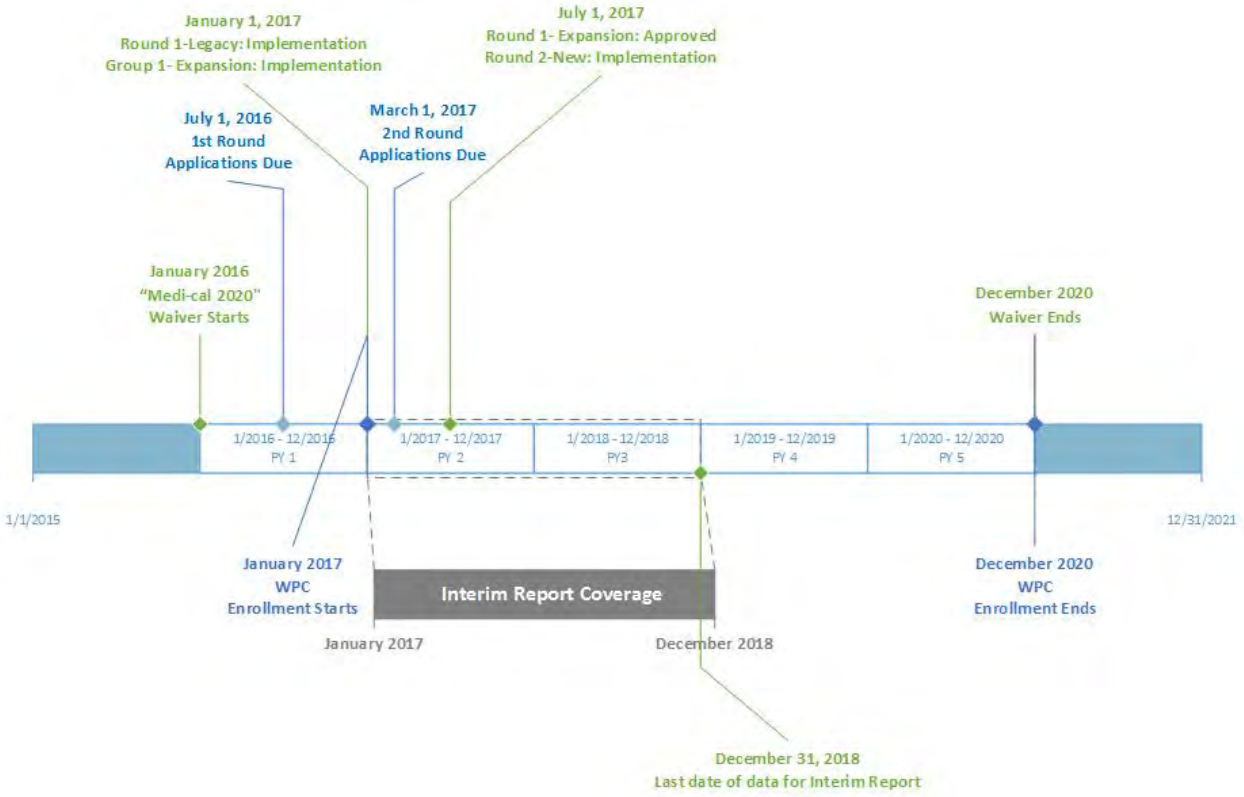
The overarching goal of WPC was to improve health and wellbeing by coordinating care across spheres of care delivery including health, behavioral health, and social services. The program was expected to be patient-centered and lead to efficient and effective use of resources. In the Special Terms and Conditions of the waiver, WPC goals were specified as:

1. Increase integration among county agencies, health plans, providers, and other entities with the participating county that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the partners participating in WPC Pilots over the long term;
2. Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
3. Reduce inappropriate emergency and inpatient utilization;
4. Improve data collection and sharing amongst partners to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
5. Achieve targeted quality and administrative improvement;
6. Increase access to housing and supportive services; and
7. Improve health outcomes for the WPC population.

WPC was implemented by Pilots that are collaborative public and private partnerships and systematically identify target populations, share data, coordinate care, and evaluate improvements in health of their enrolled population. Pilot programs were primarily organized by county agencies. Each Pilot was expected to have a Lead Entity (LE) that submitted the application to DHCS and was responsible for program implementation and submission of various reports. In their applications, Pilots described in extensive detail how they would establish the infrastructure needed for WPC, which eligible populations they were to serve, what bundles of services they would provide and at what level of reimbursement, and whether they would be responsible for pay-for-outcomes (P4O) for specific metrics.

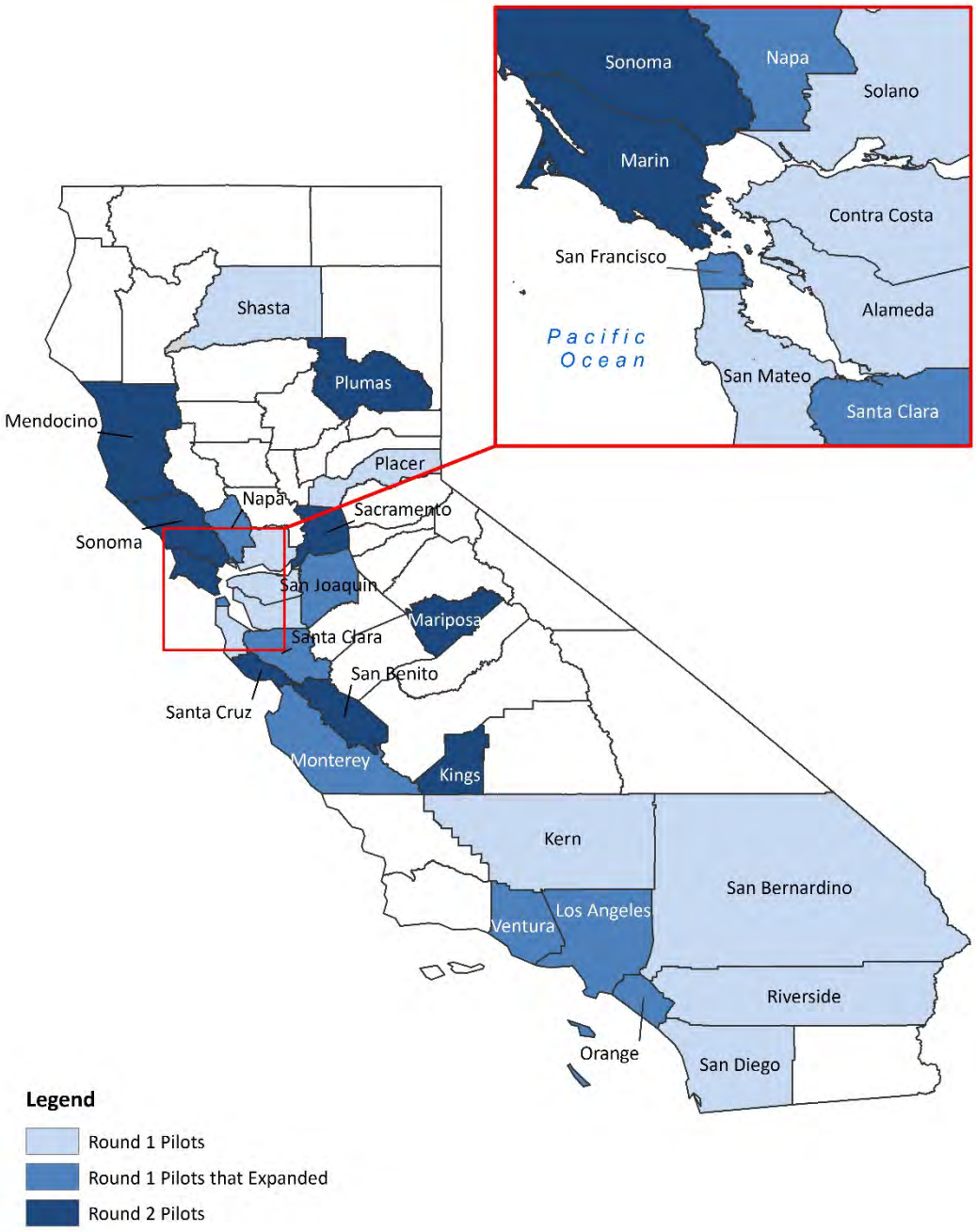
DHCS solicited two rounds of WPC Pilot applications. The first group of eighteen Pilots were awarded in November 2016 and the second group of seven Pilots were awarded in June 2017 (Exhibit 1). Program implementation began in January 2017.

Exhibit 1: Timeline of Key Whole Person Care Activities



Pilots in the first round could submit an application to expand their program in the second round. A total of 25 Pilots ultimately implemented WPC, including one Pilot that consisted of three counties. Collectively, these Pilots provided WPC services to the majority of counties in California (Exhibit 2).

Exhibit 2: Map of Participating Lead Entities and Counties in California



Source: Whole Person Care Pilot Applications (n=25).
Note: There were 25 WPC Pilots which consisted of 27 unique Lead Entities. San Benito, Mariposa, and Plumas Counties together formed the Small County Whole Person Care Collaborative (SCWPCC). Plumas left SCWPCC in September 2018.

WPC Lead Entities

Under WPC, LEs could be (1) a county; (2) a city; (3) a city and county; (4) a health or hospital authority; (5) a designated public hospital; (6) a district/municipal public hospital; (7) a federally recognized tribe; (8) a tribal health program under a Public Law 93-638 contract with the federal Indian Health Services; or (9) a consortium of any of the above. The LE, type of organization, and the abbreviated Pilot name used throughout this report are displayed in Exhibit 3. Plumas, Mariposa, and San Benito counties were considered a single Pilot and participated as part of the Small County Whole Person Care Collaborative. Plumas stopped implementation in September 2018.

Exhibit 3: WPC Pilots and Participating Lead Entities

WPC Pilot Lead Entity	Type of Lead Entity	Abbreviated Pilot Name
Alameda County Health Care Services Agency	Public health/health services agency	Alameda
Contra Costa Health Services	Healthcare system	Contra Costa
Kern Medical Center	Healthcare system	Kern
Kings County Human Services Agency	Public health/health services agency	Kings
Los Angeles County Department of Health Services	Healthcare system	Los Angeles
County of Marin Department Health and Human Services	Public health/health services agency	Marin
Mendocino County Health and Human Services Agency	Public health/health services agency	Mendocino
Monterey County Health Department	Public health/health services agency	Monterey
Napa County Health and Human Services Agency	Public health/health services agency	Napa
County of Orange, Health Care Agency	Public health/health services agency	Orange
Placer County Health and Human Services	Public health/health services agency	Placer
Riverside University Health System - Behavioral Health	Behavioral health department	Riverside
City of Sacramento	City government	Sacramento
Arrowhead Regional Medical Center	Healthcare system	San Bernardino
County of San Diego, Health and Human Services Agency	Public health/health services agency	San Diego
San Francisco Department of Public Health	Healthcare system	San Francisco
San Joaquin County Health Care Services Agency	Public health/health services agency	San Joaquin
San Mateo County Health System	Healthcare system	San Mateo
Santa Clara Valley Health and Hospital System	Healthcare system	Santa Clara
County of Santa Cruz, Health Services Agency	Public health/health services agency	Santa Cruz
Shasta County Health and Human Services Agency	Public health/health services agency	Shasta

WPC Pilot Lead Entity	Type of Lead Entity	Abbreviated Pilot Name
Plumas County Behavioral Health Department	Behavioral health department	SCWPCC
San Benito County Health and Human Services Agency	Public health/health services agency	SCWPCC
Mariposa County Human Services Department	Public health/health services agency	SCWPCC
Solano County Health and Social Services	Public health/health services agency	Solano
County of Sonoma-Department of Health Services Behavioral Health Division	Behavioral health department	Sonoma
Ventura County Health Care Agency	Healthcare system	Ventura

Source: Whole Person Care Pilot Applications (n=25).
Note: There were 25 WPC Pilots which consisted of 27 unique Lead Entities. Three WPC LEs (Mariposa, Plumas, and San Benito) formed the Small County Whole Person Care Collaborative (SCWPCC) and submitted application materials together in order to reduce administrative burden. Plumas left SCWPCC in September 2018.

Target Populations, Services, and Reporting

WPC Pilots were required to promote integration by fostering public and private partnerships. LEs were required to select a minimum of one Medi-Cal managed care health plan, one health services agency, one specialty mental health agency, one public agency, and two community partners as their partners.

WPC Pilots were also required to identify and enroll eligible Medi-Cal enrollees in their geographic area. Pilots were further allowed to identify others that were eligible for WPC but not enrolled in Medi-Cal, assist them to enroll in Medi-Cal, and subsequently enroll them in WPC.

WPC Pilot were required to select target populations in their applications from one or more of the following six groups identified by DHCS: (1) high utilizers of avoidable emergency department, hospitals, or nursing facilities (high utilizers); (2) individuals with two or more chronic physical conditions; (3) individuals with severe mental illness and/or substance use disorders (SMI/SUD); (4) individuals experiencing homelessness (homeless); (5) individuals at-risk-of-homelessness; and (6) individuals recently released from institutions, including jail or prison (justice involved).

WPC Pilots were to define individual or bundles of services provided to enrolled populations in their applications. The services bundled together ranged greatly including bundles with a broad array of services delivered to all enrollees and distinguished by level of intensity, to bundles with few services that could be mixed and matched to address the needs of enrollees. Several services such as outreach, sobering centers, and medical respite were not bundled with a per-member-per month reimbursement and were provided as needed as fee-for-service

reimbursement. Consistent with the goals of WPC, the primary services under the program included care coordination and housing support.

All WPC Pilots were required to report on individual enrollment and utilization or WPC services on a quarterly basis, as well as semi-annually report on five universal, and a minimum of four out of 10 variant metrics. Universal metrics were (1) ambulatory care- emergency department visits; (2) inpatient utilization- general hospital/acute care; (3) follow-up after hospitalization for mental illness; and (4) initiation and engagement of alcohol and other drug dependence treatment. Variant metrics included health outcomes (30-day all cause readmission; decrease jail recidivism; overall beneficiary health; high blood pressure control; control of HbA1c among patients with diabetes; depression remission at 12 months; suicide risk assessment) and housing metrics (permanent housing; housing services; and supportive housing).

WPC Funding and Pilot Payment Methodology

The total budget for WPC is $3 billion over five years. This includes $1.5 billion from participating Pilots spent to implement WPC and $1.5 billion in matching funds from the Medicaid program. Pilots submitted their requested budgets in their applications and provided a rationale and additional information on the broad categories for which funds were to be used. The categories included in the budget requests were: 1) Administrative Infrastructure, 2) Delivery Infrastructure, 3) Incentive Payments, 4) Bundled per-member-per-month (PMPM) Services, 5) Fee for Service (FFS), 6) Pay for Metric Reporting, and 7) Pay for Metric Outcomes Achievement. These categories are described in Exhibit 4.

Exhibit 4: Whole Person Care Budget Categories

Category Name	Category Description	Examples
Administrative Infrastructure	Administrative funding needed to develop and implement the WPC Pilot	Administrative staffing, information technology infrastructure
Delivery Infrastructure	Non-administrative funding with costs allocated to the WPC Pilot	Mobile Street Teams, Community Resource Databases
Incentive Payments	Funding of items intended as incentive payments for timely achievement of deliverables by downstream providers	Service Integration Team Contractors, Incentive payments for reporting outpatient services
Bundled PMPM Services	Funding for more than once service or activity to WPC enrollees	Comprehensive Complex Care Management and Housing Support Services
Fee for Service	Funding for single per encounter payment for a discrete WPC service	Sobering Center, Service Integration Team, Field-based Outreach Activity

Pay for Metric Reporting	Funding planned for collecting and reporting on pilot metrics	Number of emergency department visits, Suicide risk assessments
Pay for Metric Outcomes	Funding depending on outcome achievement with set goals used to determine payments	Reduction in the number of emergency department visits, Increase in the percentage of follow-up after hospitalization

Source: DHCS' Whole Person Care Pilot – Budget Instructions.

WPC Pilots were reimbursed for delivery of services based on PMPM bundles or FFS payment methods. PMPM bundles comprised of one or more services delivered at a set price to the WPC enrollee, while FFS items were single per-encounter payments for a discrete service. Pilots were able to receive additional financial incentives that promoted reporting (pay for reporting or P4R), improved outcomes (pay-for-outcome or P4O) or performance by partners (incentive payments). In PY 1, WPC Pilots were planning infrastructure for WPC and therefore payments reimbursed Pilots for submitting applications and reporting baseline data. In PY 2 and later years, Pilots submitted financial reports every six months detailing their activities and costs incurred for claiming in accordance with their budget.

WPC Pilots received part of their funding as payments from DHCS for achieving target values on pay-for-outcome metrics. The percent of each Pilot's budget that depended on attaining pay-for-outcome targets varied by Pilot and year, averaging around 7% with a range from 0% to 33% of Pilot budgets. Each Pilot defined the pay-for-outcome metrics and targets for which they were held accountable. Some, but not all, of these pay-for-outcome metrics aligned with the fifteen variant and universal metrics that DHCS established for WPC. The pay-for-outcome metrics that Pilots selected thus reflect Pilot priorities, and may have influenced Pilot performance on variant and universal metrics. A detailed explanation of the universal and variant metrics are available in Appendix H.

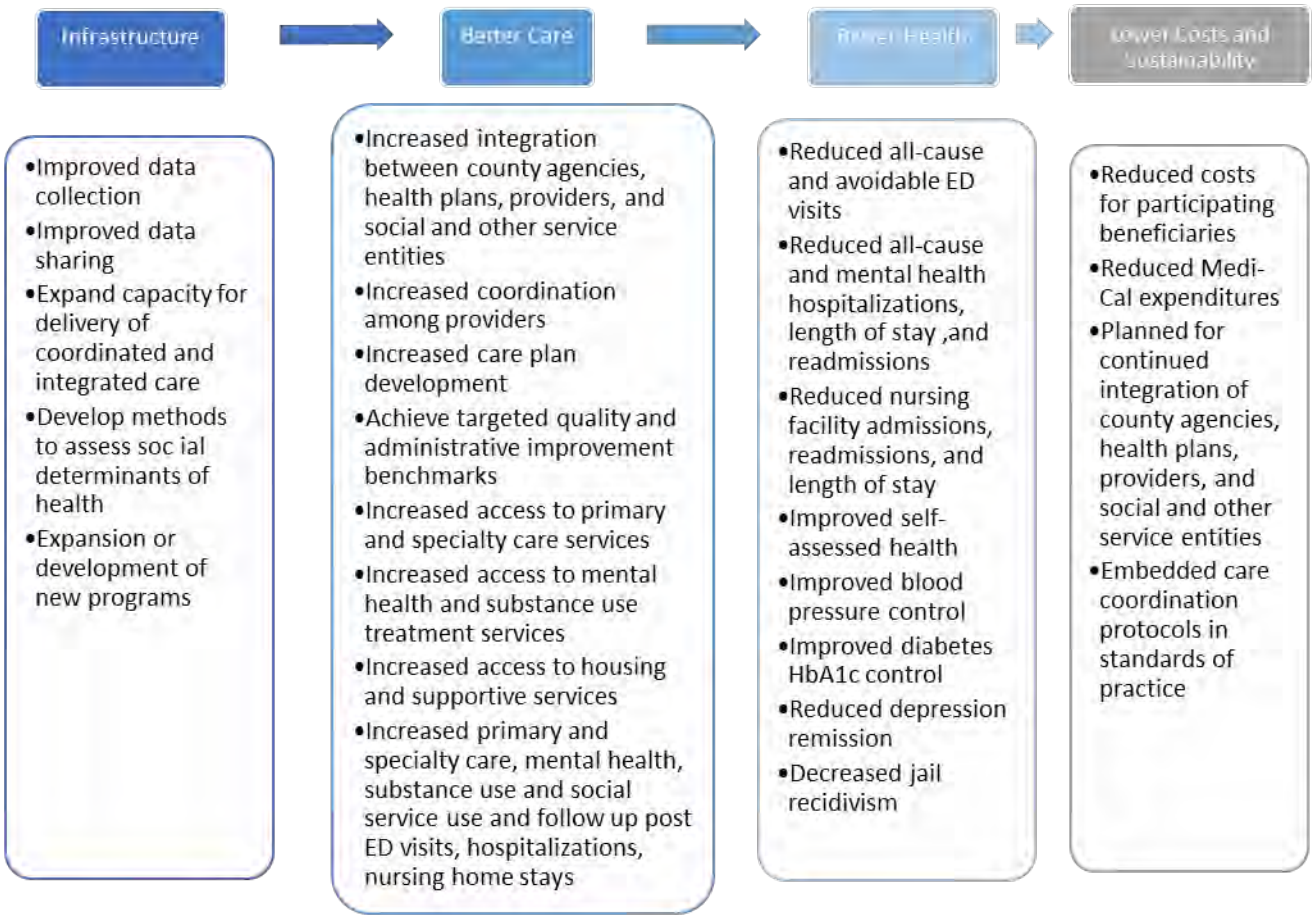
UCLA Evaluation

The UCLA Center for Health Policy Research (UCLA) was selected by DHCS to evaluate WPC. The evaluation was designed to assess whether WPC achieved its overarching goals. The evaluation broadly examined: if WPC Pilots successfully implemented their planned strategies and improved care delivery; if WPC resulted in better care and better health; and if better care and health resulted in lower costs through reductions in avoidable utilization.

Conceptual Framework

The original conceptual framework for the WPC evaluation approved by DHCS and Centers for Medicare and Medicaid Services (CMS) highlights how the program was expected to develop the needed infrastructure, improve service delivery (better care) and health outcomes (better health), and enhance sustainability of infrastructure improvements and program interventions and reduce costs through reductions in avoidable utilization (Exhibit 5).

Exhibit 5: Whole Person Care Conceptual Framework



Source: UCLA Whole Person Care Evaluation Design, 2017.

Evaluation Questions

The UCLA evaluation questions are displayed in Exhibit 6. The findings associated with each question are distributed throughout the report as shown in the exhibit. The evaluation questions were divided into overarching questions that described the program broadly, followed by specific questions that were aligned with elements of the conceptual framework.

Exhibit 6: WPC Evaluation Questions and Location of Associated Findings

Research Question	Location in Interim Report
Overarching Questions	
1. What are the demographics of WPC enrollees? What services did they receive?	Enrollee Demographics, Health Status, and Prior Health Care Utilization; WPC Services Offered and Delivered
2. What key factors aided or hindered the success of specific strategies in implementing or achieving the intended outcomes, and what measures are WPC Pilots taking to address these barriers?	Conclusions and Next Steps; Health Information Technology and Data Sharing Infrastructure; Identification, Enrollment, and Engagement of Eligible Medi-Cal Beneficiaries; WPC Care Coordination
3. What are the structural differences of the various WPC Pilots and how are differential WPC Pilot outcomes related to structural differences?	Structure of WPC Pilots
Infrastructure	
4. To what extent did the WPC Pilot: A) develop collaborative leadership, infrastructure, and systematic coordination among public and private WPC Pilot partners, including county agencies, health plans, providers, and other partners that serve high-risk, high-utilizing Medi-Cal beneficiaries; and B) achieve the approved application deliverables relating to collaboration, infrastructure, and coordination?	Structure of WPC Pilots
5. To what extent did the Pilot: A) improve data collection and information sharing amongst local entities to support identification of target populations, ongoing case management, monitoring, and strategic program improvements in a sustainable fashion; and B) achieve the approved application deliverables relating to data collection and information sharing?	Health Information Technology and Data Sharing Infrastructure
Better Care	
6. To what extent did the Pilot: A) improve comprehensive care coordination, including in-real-time coordination, across participating entities; and B) achieve the approved application deliverables relating to care coordination?	WPC Care Coordination
7. To what extent did the Pilot: A) increase appropriate access to care and social services; and B) achieve approved application deliverables relating to WPC service delivery?	Better Care; WPC Services Offered and Delivered
8. To what extent did the Pilot increase access to housing and supportive services and improve housing stability?	Homeless WPC Enrollee Services and Outcomes
Better Health	

Research Question	Location in Interim Report
9. To what extent did the Pilot: A) improve beneficiary care and health outcomes, including reduction of avoidable utilization of emergency and inpatient services; and B) improve outcomes such as controlled blood pressure and Hemoglobin A1c (HbA1c)?	Better Health
Lower Costs and Sustainability	
10. To what extent did WPC Pilots reduce costs of care for WPC enrollees compared to the control group and were total Medi-Cal expenditures reduced during the WPC program?	Lower Costs
11. What lasting collaboration between Pilot participants and care coordination protocols will continue after the WPC program? In addition, how will counties ensure that improvements achieved by the Pilots will be sustained after WPC program funding is exhausted?	Sustainability

Source: UCLA Whole Person Care Evaluation Design, 2017.

Data Sources

UCLA used several qualitative and quantitative data sources for the evaluation.

Qualitative data included: (1) WPC Pilot applications to DHCS, (2) interim surveys of LEs, (3) interim surveys of Pilot partners, (4) follow-up interviews with LEs including leadership and frontline staff as well as selected partners (5) WPC narrative reports submitted to DHCS, and (6) narrative report attachments, including Plan-Do-Study-Act (PDSA) reports.

WPC applications included Pilots identification of the target population; a description of the WPC Pilot structure, partnerships for implementation, and the needs of the target population; services that would be provided and interventions applied; and the associated funding request.

From July-September 2018, UCLA fielded a web-based interim survey to LE leadership in all 27 WPC Pilots. Questions assessed health information technology infrastructure, specific activities related to project implementation, ratings of level of effort, staffing and workforce development, participation in quality improvement activities, and challenges and solutions. Additionally, from July-October 2018, UCLA fielded an interim survey to key partners that was completed by 227 partner representatives from 25 WPC Pilots (Sonoma was not included due to delayed implementation, while Plumas was not included because they stopped implementation in September 2018). Questions assessed partners' motivation to participate, collaboration with the LE, and perceived impact of the WPC program.

The interim Pilot and partner surveys were followed by in-person or telephone follow-up interviews, which were conducted from September 2018-Februrary 2019. Interviews were conducted with both: (1) key leadership and management, such as project managers, administrators, and directors of the WPC program and (2) frontline staff, such as care coordinators, public health nurses, and social workers in all 27 WPC Pilots. The key informant

interview protocol contained a set of standardized questions asked of each WPC Pilot, as well as follow-up questions specific to the WPC Pilot's individual survey responses, to obtain clarification and additional detail on various aspects of project implementation. Interviews were systematically coded to determine key themes across WPC Pilots.

Narrative reports were submitted to DHCS bi-annually (PY 2 Mid-Year, PY 2 Annual, PY 3 Mid-Year, and PY 3 Annual). These data included a summary of program achievements and challenges in care coordination, data and information sharing, and data reporting. Narrative reports were systematically coded to determine key themes across WPC Pilots. Pilots submitted PDSA reports along with their semi-annual reports, which outlined specific quality improvement projects and provided a description of change-management plans and processes to achieve specific Pilot goals related to care coordination, data sharing, and metrics.

Quantitative data included Pilot-reported progress in universal and variant metrics semi-annually as well as monthly enrollment and utilization reports submitted to DHCS on a quarterly basis. UCLA also received Medi-Cal enrollment and claims data from January 2015 to December 2018 including PY 2 and PY 3 as well as PY 1 and an additional year prior to WPC implementation. Data were comprehensive and included all individuals reported as enrolled in WPC during PY 2 and PY 3 and for a group of potential controls that met specific criteria.

Analytic Methods

UCLA analyzed all data using appropriate qualitative and quantitative methods. The qualitative methods included extracting relevant information from applications, coding and developing themes from the narrative reports, coding and developing themes from the transcribed follow-up interviews, and reporting descriptive data from survey results. A detailed explanation of the qualitative analyses is available in Appendices C, D, E, and F.

The quantitative methods included calculating average weighted Pilot-reported metrics overall and by selected subgroups, descriptive assessment of WPC enrollee characteristics, and conducting difference-in-difference (DD) analyses of WPC enrollees vs. a constructed control group using the Medi-Cal data. UCLA used doubly robust propensity score methods and random effect models for the DD analyses. A detailed explanation of the Pilot-reported metrics and the DD analyses are available in Appendix B and Appendix A, respectively.

Limitations

Survey and interview data are subject to recall or acquiescence bias. In addition, these data reflected the early phase of WPC implementation and do not indicate progress made afterwards. Similarly, mid-year and annual narrative reports were reported by Pilots and could

not be independently verified. A more detailed explanation of the limitations of the qualitative analysis is available in Appendices C, D, E, and F.

Enrollment in WPC was not always accompanied with receipt of services as some enrollees were difficult to find following enrollment. Additionally, administrative data lacked information on reason for utilization and other contextual data. The Pilot-reported metrics included clinical information from sources such as medical records that were not available to UCLA. A more detailed explanation of the limitations of the quantitative analysis is available in Appendix A.

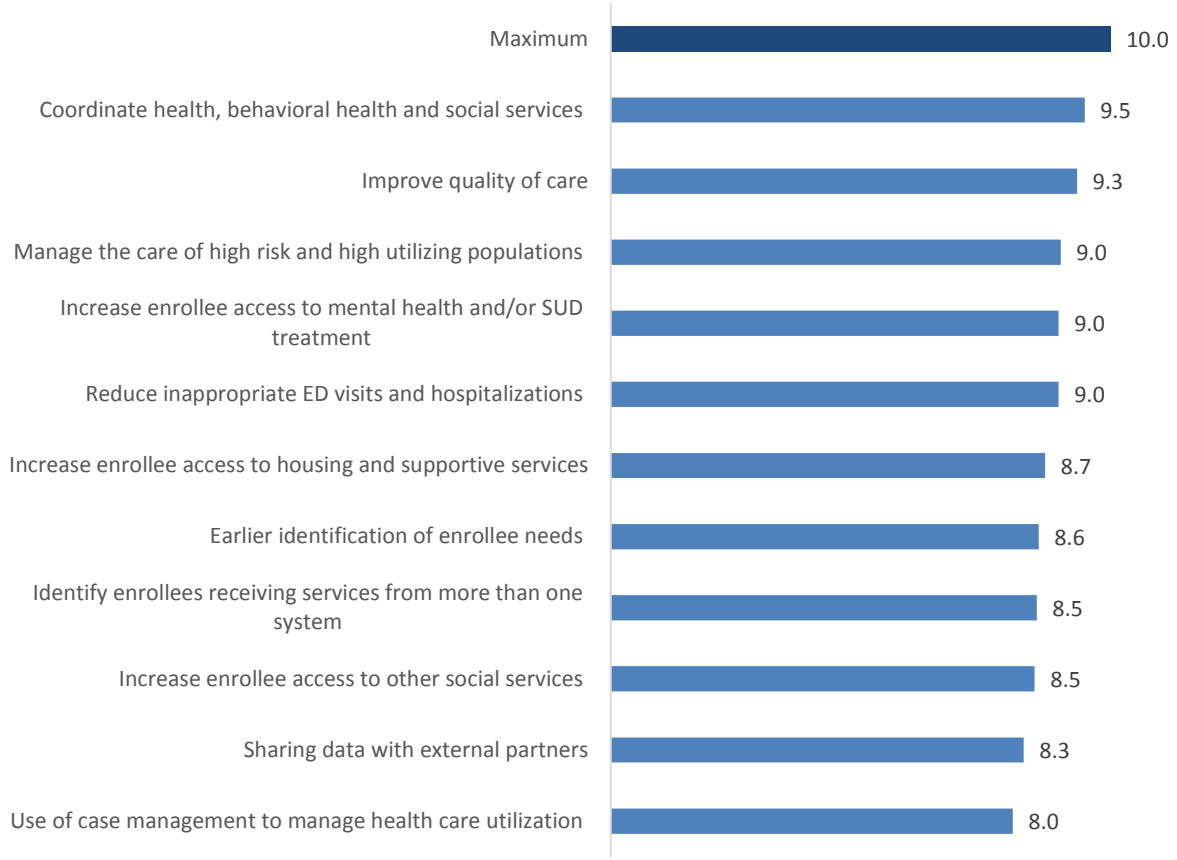
Chapter 3: Motivation for WPC Pilot Participation

In the interim Pilot survey and follow-up interviews, WPC Pilots were asked to describe their motivation for participation in WPC. Pilots were asked about fit of WPC with strategic priorities, synergies with existing initiatives, and specific goals such as improving outcomes. Understanding this motivation was expected to have implications for how Pilots structured and implemented their programs; it is also expected to have consequences for sustainability of WPC interventions after the end of the demonstration.

Fit with Strategic Priorities

In the interim Pilot survey, Pilots were asked to rate the extent to which their programs' goals and/or program components fit with their overall strategic priorities from 0 (very low) to 10 (very high). Overall, Pilots rated (1) coordinating health, behavioral health, and social services (9.5 of 10); (2) improving quality of care (9.3); and (3) managing the care of high risk and high utilizing populations (9.0) the highest (Exhibit 7). All goals were rated 8.0 or higher, suggesting close alignment of WPC with the Pilots' strategic priorities.

Exhibit 7: WPC Pilots' Rating of the Fit of WPC Goals with Strategic Priorities



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.
Note: WPC Pilots could select "Not Applicable" when appropriate. Categories where at least one Pilot selected N/A included: use of case management to manage health care utilization, increase enrollee access to housing and supportive services, increase enrollee access to mental health/and or SUD treatment, managed the care of high risk and high utilizing populations.

Existing strategic priorities of an LE often guided the focus and primary goals of WPC Pilots. In follow-up interviews, Pilots were asked to identify their major strategic priorities, which were generally to improve (1) integration of care/reducing silos, (2) "value" of care (i.e., improved quality at same or reduced cost), and (3) access to patient-centered care that accounted for enrollee needs and preferences.

> *"We want a fully integrated system that brings disciplines together under one roof… that is the beauty of our WPC model."*
>
> *–Contra Costa*

During follow-up interviews, Pilots (Contra Costa, Napa) reported WPC provided the stimulus to break down siloed approaches to care as agencies have many shared clients with complex

> *"Our health department has been focusing and concentrating on health equity for a number of years … I think that Whole Person Care just fit really well into those priorities of serving a population that was not getting the level of services that they needed in order to become well… It is a very high priority..."*
>
> *–Monterey*

needs that require a multi-disciplinary understanding and approach. Sacramento also highlighted their increased focus on improving the quality and delivery of healthcare to safety-net populations, with a goal of transitioning to more value-based strategies and reducing costs. Furthermore, a common key strategy across Pilots was to increase accessibility of care to address enrollees' needs and preferences. Los Angeles emphasized the necessity of "meeting clients where they are at" in order to effectively serve a high-need population who often had difficulty engaging with traditional systems of care.

Pilots discussed strategic priorities related to working in new ways with partner organizations to address community priorities. For example, Placer mentioned community priorities included ending homelessness, decreasing stigma with accessing certain types of services within the local community, and reducing inappropriate utilization of the emergency department. Alameda and Contra Costa also discussed developing improved electronic data sharing and infrastructure.

Synergies with Other Programs and Initiatives

In many cases, prior initiatives set the foundation for work in WPC, while current initiatives offered unique opportunities for collaboration and synergy with WPC activities. As emphasized in follow-up interviews, many counties had some basic infrastructure for case management and/or care coordination prior to WPC. However, WPC provided an opportunity to expand their scope and to commit to effective care coordination, such as ensuring follow-up after referrals, providing data systems to share information on mutual clients, and formalization of referral protocols and pathways.

WPC Pilots emphasized in follow-up interviews that their Pilots were designed to address the most pressing needs of the local community. Oftentimes, specific WPC Pilot target populations and program areas were a result of prior efforts. For example, Pilots discussed building upon existing outreach and engagement models, homeless services, and targeted case management programs. Pilots frequently referenced existing community based programs, initiatives, and grants that directly contributed to WPC implementation; examples included Coordinated Entry Systems, Street Medicine programs, and Jail Diversion programs. More specifically, existing initiatives may have provided data infrastructure, actionable lessons learned, staff training, and partnership networks from which WPC was developed upon.

Exhibit 8 outlines influential prior initiatives as highlighted by WPC Pilots.

Exhibit 8: Selected Examples of Influential Prior Initiatives on WPC

Elements of Prior Initiative	WPC Pilot	Selected Examples
Care coordination and/or case management	San Diego	San Diego recognized WPC as an opportunity to tie multiple initiatives together within the county (e.g., Full Service Partnerships (FSP), Project One for All, Drug Medi-Cal waiver), through a central coordination model.
	San Bernardino	Frontline staff in San Bernardino learned from prior interactions with clients, the necessity of walking enrollees through discharge paperwork and educating them on next steps.
Housing	Marin	Leadership in Marin strategically took a "housing first" approach (i.e., emphasis on permanent housing instead of emergency shelters/transitional housing systems). Prior to WPC, Marin hired two homeless policy analysts, who were leading housing efforts and working towards the development of a formal coordinated entry system. When WPC began, Marin was able to build upon existing work in this area.
	Los Angeles	Housing for Health was a previously established program through the Department of Health Services. Housing for Health was the primary program responsible for providing temporary, bridge, interim, and permanent supportive housing to low-income clients, along with intensive case management services. WPC worked closely with the Housing for Health program to provide services for their homeless target population.
	San Francisco	San Francisco developed a homeless outreach team over ten years ago to address homelessness and connect individuals on the streets to services. The model has evolved into street medicine; "meeting clients where they're at" and providing basic medical services in a convenient and accessible location for homeless populations was a primary focus of San Francisco's WPC Pilot.
	San Benito (SCWPCC)	San Benito developed a local collaborative called "Housing for the Homeless," which convened key government agencies and community based organizations, with the intentions of building the county's first (and only) homeless shelter. The homeless shelter was built prior to WPC, yet has been the central location for coordinating mental health, physical health, and social needs throughout the WPC Pilot.
Mental health	Santa Clara	Santa Clara had previously utilized TeleHealth remote monitoring devices and occupational therapists and nurses to provide housing support to vulnerable clients, through Mental Health Services Act (MHSA) dollars. WPC allowed Santa Clara to expand and make these supports more robust.
	Sonoma	Sonoma had a targeted outreach and engagement program, funded by MHSA dollars, to engage hard-to-reach populations and improve access to mental healthcare. This program provided a foundation for WPC efforts.

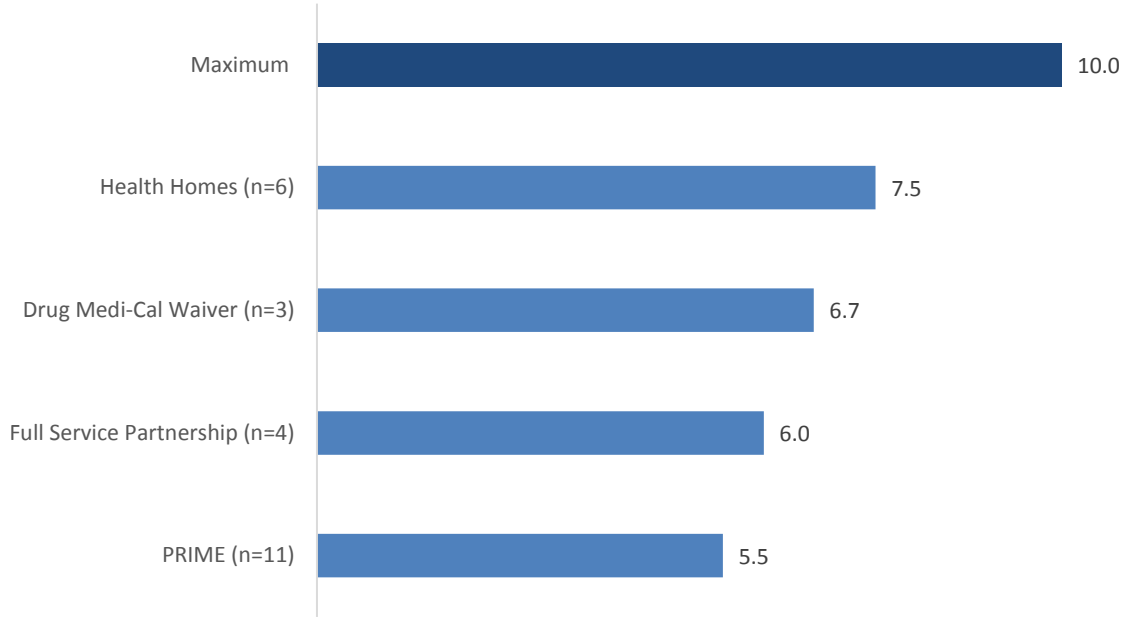
Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

In the interim Pilot survey, Pilots reported on synergies with alternative and concurrent programs. Seventeen WPC Pilots (63%) reported participating in initiatives alternative and concurrent to WPC that demonstrated similar goals, services, and/or clients served (data not shown). Eleven of the 27 WPC Pilots reported synergistic work with PRIME (41%), six with

Health Homes (22%), four with Full Service Partnerships (15%), and eleven with the Drug Medi-Cal Waiver (11%; data not shown).

WPC Pilots were also asked to rate the level of synergy with these programs on a scale of 0 (no synergy) to 10 (extremely high synergy). Pilots found the most synergy with Health Homes (7.5 of 10), followed by the Drug Medi-Cal Waiver (6.7), Full Service Partnerships (6.0), and PRIME (5.5; Exhibit 9). Common areas of overlap between WPC and existing initiatives included working with high-need Medi-Cal beneficiaries, need for advanced data collection and sharing electronics systems, and similar required reporting on healthcare metrics such as emergency department utilization and hospitalizations.

Exhibit 9: WPC Pilots Rating of Synergy with Other Alternative and Concurrent Programs



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.
Note: Sample sizes for PRIME, Full Service Partnership, Drug Medi-Cal Waiver, and Health Homes ranged from 3-11 as WPC Pilots could select "Not Applicable" when appropriate.

In follow-up interviews, Pilots spoke about different types of synergies with alternative and concurrent programs or initiatives. Exhibit 10 highlights examples of some of these synergies, with included other programs under the "Medi-Cal 2020" Waiver, as well as local and existing programs within WPC counties.

Exhibit 10: Selected Examples of Synergies with Alternative and Concurrent Programs and Initiatives

Elements of Concurrent Program	WPC Pilot	Selected Examples
Pre-existing case management services	Contra Costa	Care managers in Contra Costa were trained to distinguish when services might have been duplicative with other programs; the Pilot noted that for the most part there was always room for services from multiple programs, particularly as the focus of WPC is to assist enrollees with social service needs. Oftentimes, WPC complemented existing programs by filling in gaps. Contra Costa also established a "Waiver Integration Team" with a key goal of defining case management across participating partners.
	Los Angeles	Los Angeles strategically used funding from WPC and Prop 47 for their community based intensive case management service. Prop 47 covered gaps in WPC funding to serve justice-involved clients.
Justice-involved services	San Joaquin	Similar to their WPC target population goals, San Joaquin concurrently developed their Law Enforcement Assisted Diversion (LEAD) program, a pilot program offering outreach and engagement in hopes of diverting individuals from the criminal justice system. Because the services offered were very similar between WPC and LEAD, there was a degree of strategic staff crossover between projects.
Mental health services	Placer	Placer's Adult System and Care (ASAC) Division provided a lot of similar types of services as WPC. However, ASAC's caseloads were larger and more focused on mental health. Although there were some coordination of services within ASAC, the implementation of WPC provided support that had been missing in the county for some time.
Medi-Cal Section 1115 programs	Santa Clara	In Santa Clara, metric and data gathering for the PRIME and Global Payment Program (GPP) programs helped inform what was being done under WPC. The county worked to understand where the intersection lies between all of their participating waiver programs in order to prevent duplication of services.
	Marin	Marin emphasized how resources were spread thin across participation in multiple Medi-Cal waivers within the County. Although collaborating would have been ideal, Marin felt there were significant barriers to this including limited staff and resources and potentially competing priorities across projects.
	Riverside	Riverside's WPC Pilot was planned based on previous work with initiatives like PRIME and Inland Empire health plan's case management program. The Pilot took the same approach to WPC planning that it did with other initiatives to decide which complex population to target for their project.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

> *"We understand that we have different requirements and different deliverables for each of the different programs, but we use the same teams and we work towards trying to create as much uniformity as we can across."*
>
> *–Kern*

Despite similar aims, Pilots indicated in follow-up interviews that while synergy existed between concurrent initiatives, the high level of effort in initial development and operations of WPC created challenges in encouraging regular collaboration between ongoing projects. Still, other WPC Pilots strategically organized their teams to work on the implementation of multiple Medi-Cal waivers simultaneously. Among these Pilots, several including Contra Costa and Santa Clara, emphasized the importance of establishing leadership teams to strategize and leverage resources across all Medi-Cal waiver programs.

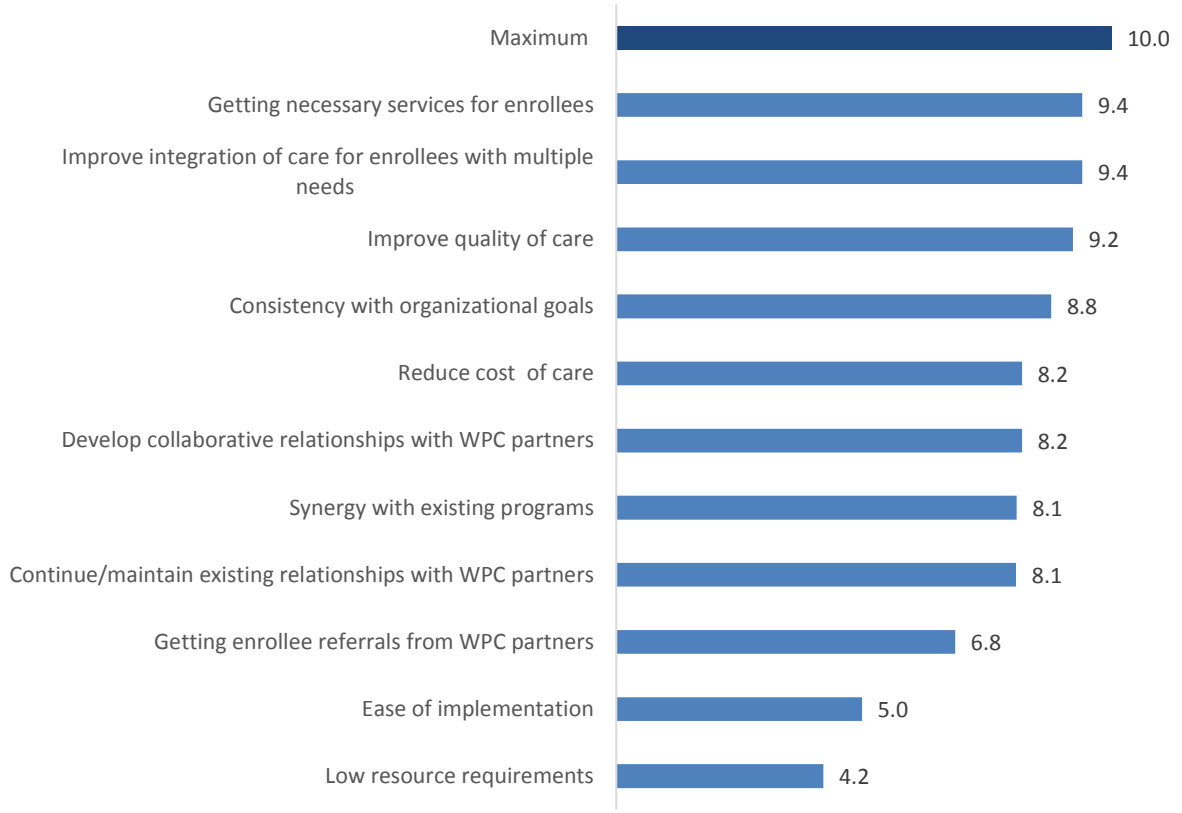
Several WPC Pilots viewed Health Homes as a sustainability vehicle for WPC care coordination activities despite different levels of involvement with participating Medi-Cal managed care plans. However, some Pilots reported confusion over eligibility requirements between Health Homes and WPC. Recognizing that both Health Homes and WPC provided care management and care coordination services and also aiming to avoid duplication of services, Pilots faced challenges determining which program might be the best fit for prospective enrollees. WPC Pilots noted that while both programs provided similar services, they were planned and operated by different entities leading to implementation challenges.

Specific Goals

In the interim Pilot survey, Pilots were asked to rate the importance of specific factors related to quality, cost, and integration of services in their decision to participate in WPC. On a scale of 0 (very low) to 10 (very high), Pilots rated the majority of factors as eight or higher (Exhibit 11).

On average, the top three factors contributing to the decision to participate in WPC included: (1) getting necessary services for enrollees (9.4 of 10); (2) improving integration of care for enrollees with multiple needs (9.4); (3) and improving quality of care (9.2). Low resource requirements (4.2) and ease of implementation (5.0) were rated as lower levels of importance in the decision of Pilots to participate in WPC.

Exhibit 11: Average Rating by Pilots on the Importance of Factors in the Decision to Participate in WPC



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.
Note: Sample sizes for low resource requirements, ease of implementation, getting enrollee referrals from WPC partners, and synergy with existing programs ranged from 22 to 26 as WPC Pilots could select "Not Applicable" when appropriate.

In follow-up interviews, WPC leaders were asked how they determined which organizations to partner with for WPC. Many reported selecting partners to address identified gaps in care for target populations, maintain and strengthen pre-existing relationships, develop new relationships, and/or to ensure partners complemented other initiatives such as PRIME or the Full Service Partnership programs. Several Pilots (e.g., Plumas, Mendocino) described including all available partners and attributed continued gaps in care to absence of these resources within their local communities rather than inability to engage needed partners (e.g., no hospitals or substance abuse treatment in a particular service area). Illustrative examples of the rationale for selecting specific Partners are provided in Exhibit 12.

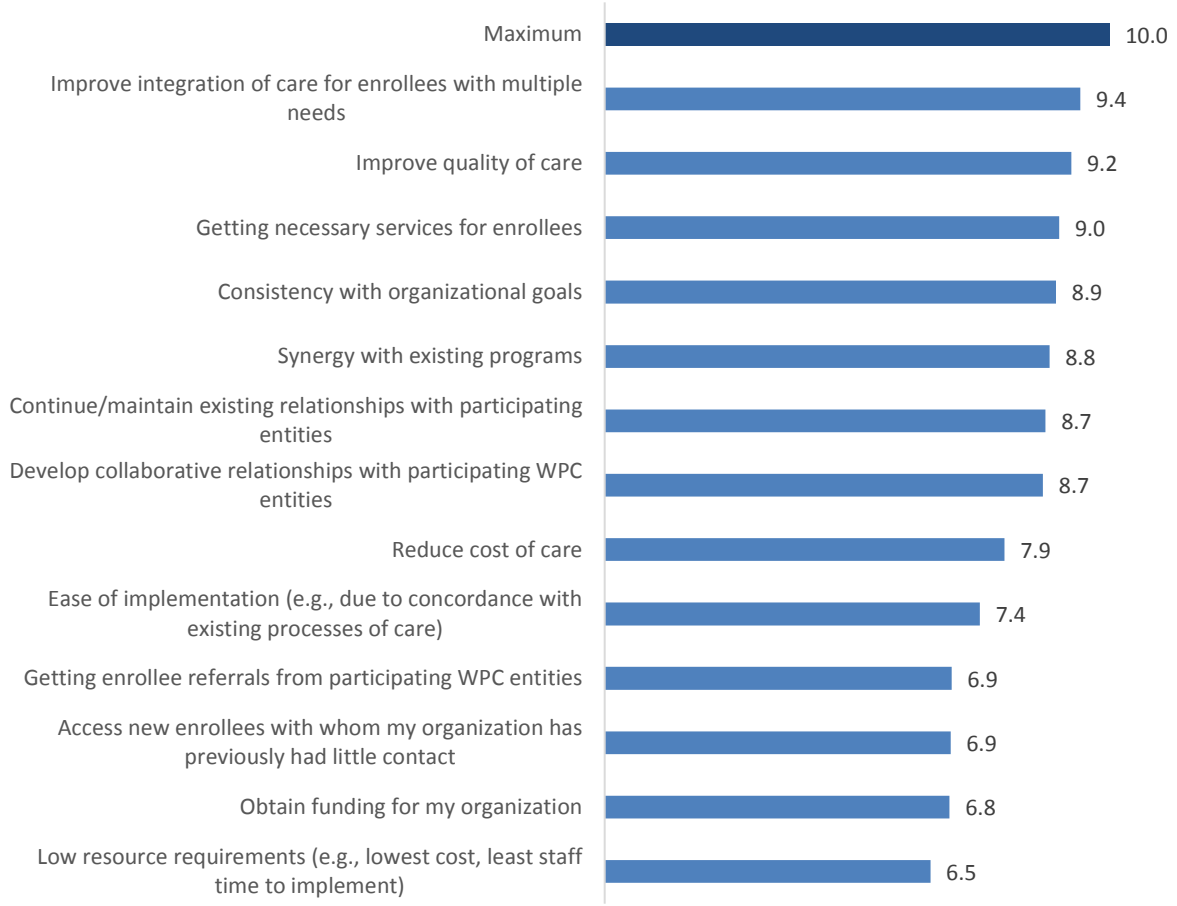
Exhibit 12: Selected Examples of WPC Pilots' Decisions for Choice of Partners

Determination Element	WPC Pilot	Selected Examples
Met target population needs	San Joaquin	San Joaquin noted that inappropriate use of the ED for primary care resulted in inclusion of partner such as hospitals and community medical centers meant to provide primary care services and reduce ED usage.
	San Diego	San Diego partnered with and convened organizations targeting similar populations to achieve similar goals including housing providers, behavioral health services, hospitals, a community clinic, and legal aid.
Participated in complementary initiatives	Alameda	Alameda purposefully included partner organizations already involved in a county-wide patient satisfaction initiative and/or in a pre-existing Health Care for Homeless program.
Prior existing relationships	Kern	Kern's Pilot was led by the local hospital authority. In selecting partners, Kern made concerted effort to identify key stakeholders within the county to maintain and strengthen those relationships.
	Marin	As a smaller county, Marin's Pilot included all available partners and resources.
	Santa Clara	Santa Clara relied on pre-existing relationships to facilitate partner engagement. They had a prior relationship with the county Public Health Department, who in turn used its own relationships to help bring in local provider organizations.
New partner relationship opportunity	Ventura	Ventura included all county agencies and community partners in an early vision development process, and used these consultations to identify and engage partners in WPC.
	Orange	Orange had not previously worked with Behavioral Health Services, but leveraged conversations about improving outcomes for shared clients to facilitate buy-in.
	Sonoma	Sonoma used WPC to purposefully build relationships with other internal county agencies and departments, including Health Services, Human Services, Community Development, Probation, Child Support Services, and Criminal Justice.

Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

In the interim partner survey, WPC partners were asked to rate the importance of different factors in their organizations' decisions to participate in the WPC program on a scale of 0 (not at all important) to 10 (very important). The three factors identified by partners as most important to their decision to participate in WPC included improving coordination or integration of care for enrollees with multiple needs (mean rating of 9.4 of 10), improving quality of care (9.2), and getting necessary services for enrollees (9.0; Exhibit 13). The factors identified as less important to partners' decision to participate in WPC were: access to new enrollees or referrals (6.9), obtaining funding for their organizations (6.8), and low resource requirements for implementing WPC (6.5).

Exhibit 13: Overall Average Rating by Partners on the Importance of Factors in their Organization's Decision to Participate in WPC



Source: Whole Person Care Partner Survey (n=227), July-October 2018.
Note: Sample size for selection of factors ranged from 177 to 215 as partner organizations could select "Not Applicable" when appropriate.

Chapter 4: Structure of WPC Pilots

WPC Pilots were required to "develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term". The first half of this chapter addresses the first part of the following evaluation question: "what are the structural differences of the various Pilots and how are differential Pilot outcomes related to structural differences?" The 25 WPC Pilots were led by 27 Lead Entities (LEs). LEs served as the primary administrative and governing body throughout the duration of WPC.

The second half of this chapter addresses the following UCLA evaluation question: "to what extent did the Pilot (a) develop collaborative leadership, infrastructure, and systematic coordination among public and private WPC Pilot entities, including county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries; and (b) achieve the approved application deliverables relating to collaboration, infrastructure, and coordination?"

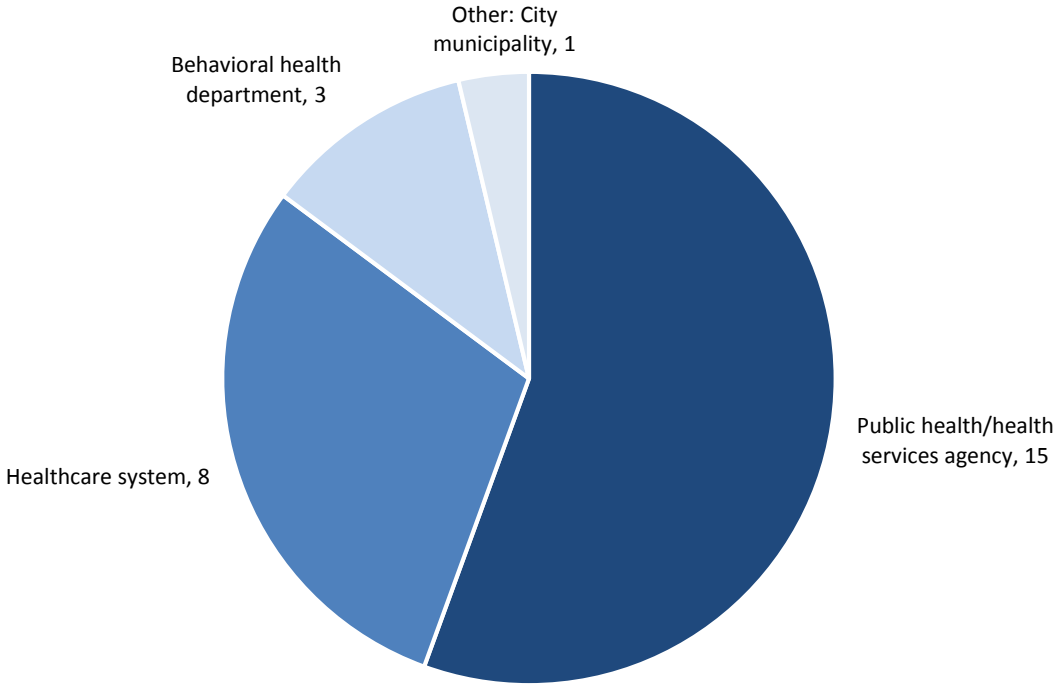
Data sources for this chapter included 25 WPC Pilot applications, including a single application from three Pilots, interim surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots, as well as an interim survey of 227 partner organizations. Additional qualitative data around challenges and solutions were provided in 25 WPC mid-year and annual narrative reports. For additional detail on data sources and methodology please see the Analytic Methods and Appendices C, D, E, and F.

Organizational Structure

WPC Pilots selected LEs to be responsible for program implementation and administrative management. The majority of WPC Pilots were led by a single LE. Based on their Pilot application, three LEs (Mariposa, Plumas, and San Benito) formed the Small County Whole Person Care Collaborative (SCWPCC) because "the scope, anticipated costs, and local infrastructure needed to fulfill the requirements for participation in the WPC Pilot exceeded their local capacity as individual counties." [1] The counties in this collaborative believed that they could expand their capacity by joining together in the following ways: shared infrastructure and development of a client data management and care coordination system, creation of a learning collaborative, and centralized financial claiming and data reporting to DHCS. [2] In September 2018, Plumas left the Small County Whole Person Care Collaborative and ended their WPC program, citing limited resources/capacity and staffing issues in UCLA follow-up interviews. In this report, Plumas is included in data collection and reporting prior to September 2018.

UCLA categorized WPC LEs into four primary organizational types: public health/health services agencies, healthcare systems (e.g., hospital authority or an integrated system that included a public hospital), behavioral health departments, and other. As shown in Exhibit 14, fifteen of the LEs for WPC Pilots were public health or health services agencies (56%), followed by eight healthcare systems (30%), and three behavioral health departments (11%). The LE in Sacramento was a city municipality.

Exhibit 14: Types of Lead Entities of WPC Pilots



Source: Whole Person Care Pilot Applications (n=25), 2016.
Notes: There were 25 WPC Pilots, which consisted of 27 unique Lead Entities. Three WPC LEs (Mariposa, Plumas, and San Benito) formed the Small County Whole Person Care Collaborative (SCWPCC) and submitted applications materials together in order to reduce administrative burden. Plumas left the SCWPCC in September 2018.

In follow-up interviews, Pilots described that the choice of LE was based on which organization was best equipped to provide overall administrative and strategic guidance. For example, in Plumas County (SCWPCC), the County Behavioral Health Department was described as the logical choice for LE because of the program's emphasis on facilitating enrollee access to behavioral health services. Similarly, in San Francisco, the Department of Public Health was selected as the LE due to its prior experience working with the target population (homeless individuals) and engagement in prior initiatives aligned with WPC goals, such as the Street Medicine program. Finally, Contra Costa County chose Contra Costa Health Services as their LE because this agency served as the "umbrella agency" for the county's behavioral health services, public health, emergency medical services, and health plan. Additional information on

Partnerships is provided below.

Target Populations

WPC Pilots could choose to focus on one or more of the six target populations in their applications, as described in the Introduction. The attribution of enrollees to a target population was at the discretion of Pilots. There was inherent overlap in eligibility of enrollees for multiple categories. For example, a single enrollee may have multiple chronic conditions along with serious mental illness (SMI) and substance use disorder (SUD) and had multiple avoidable emergency department visits in the past. Therefore, enrollees in each target population could have qualified for others, leaving Pilots to decide how to attribute enrollees.

Exhibit 15 highlights the primary target population(s) by Pilot as of March 2019. Eighteen Pilots had more than one primary target population (67%). Of the nine Pilots that only identified one target population, five Pilots focused on high-utilizers, which was the broadest, most inclusive category. These Pilots included Contra Costa, San Bernardino, San Mateo, Santa Clara, and Ventura.

Exhibit 15: Selection of Primary Target Population by WPC Pilot

WPC Pilot	High Utilizers	Chronic Physical Conditions	Serious Mental Illness/ Substance Use Disorder	Homeless	At-risk-of-Homelessness	Justice-Involved	Total Number of Target Population Selected by Each Pilot
Alameda	X			X			**2**
Contra Costa	X						**1**
Kern	X			X	X	X	**4**
Kings		X	X				**2**
Los Angeles	X	X	X	X	X	X	**6**
Marin	X			X	X		**3**
Mendocino			X				**1**
Monterey				X			**1**
Napa				X	X		**2**
Orange			X	X			**2**
Placer	X	X	X	X	X	X	**6**
Riverside						X	**1**
Sacramento	X			X			**2**
San Bernardino	X						**1**
San Diego	X			X	X		**3**
San Francisco				X			**1**

WPC Pilot	High Utilizers	Chronic Physical Conditions	Serious Mental Illness/ Substance Use Disorder	Homeless	At-risk-of-Homelessness	Justice-Involved	Total Number of Target Population Selected by Each Pilot
San Joaquin	X		X	X	X		**4**
San Mateo	X						**1**
Santa Clara	X						**1**
Santa Cruz		X	X				**2**
Shasta	X	X	X	X	X		**5**
Solano	X		X				**2**
Sonoma			X	X	X		**3**
Ventura	X						**1**
San Benito (SCWPCC)	X			X	X		**3**
Mariposa (SCWPCC)	X		X				**2**
Plumas (SCWPCC)			X	X			**2**
Total Number of Pilots that Selected Each Target Population	**17**	**5**	**13**	**16**	**10**	**4**	

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.
Note: SCWPCC is the Small County Whole Person Care Collaborative

As shown in Exhibit 15, the majority of Pilots, seventeen, focused on high utilizers (63%), sixteen focused on homeless (59%) populations, followed by thirteen who focused on individuals with serious mental illness/substance use disorder (48%), ten on at-risk-of-homelessness (37%), five on populations with chronic physical conditions (19%), and four on justice-involved populations (15%).

Pilots had discretion in choosing inclusion and exclusion criteria for attribution of enrollees to a target population. Exhibit 16 displays variations in these criteria in selected Pilot applications. During follow-up interviews, nine Pilots reported adding or removing inclusion criteria for some target populations to better meet WPC program goals and/or patient needs. These changes did not require prior approval from DHCS. Additional information on target populations is presented in the Appendix J.

Exhibit 16: Primary Target Population Criteria by WPC Pilot

Target Populations	WPC Pilot	Target Population Criteria
High Utilizers	Shasta	Adults ages 18 to 64 with two or more ED visits or hospitalizations in the last three months and are homeless or at-risk of homelessness, based on HUD criteria (people living in a place not meant for human habitation, in emergency shelter, in transitional housing, or exiting an institution where they temporarily resided). Potential enrollees also needed to fulfil one or more of the following criteria: • SMI diagnosis • SUD diagnosis • Undiagnosed/undisclosed opioid addiction
	Kern	The top 10% of Medi-Cal beneficiaries by spending who had a diagnosis of a mental disorder, substance use disorder, traumatic brain injury, dementia or opioid use, two or more chronic conditions, and/or repeated incidents of avoidable emergency use, hospital admissions or nursing facility placement.
Chronic Physical Conditions	Kings	Individuals must have a substance use disorder, mental health issue or chronic health condition of diabetes or high blood pressure.
	Los Angeles	Individuals with three or more admissions (medical or psychiatric) within the last six months and at least one of the following: 1) one or more avoidable hospital admissions related to a chronic medical problem, 2) homelessness (based on HUD criteria: people living in a place not meant for human habitation, in emergency shelter, in transitional housing, or exiting an institution where they temporarily resided), 3) SUD, 4) mental health disorder, and/or 5) incarceration within the last month.
Serious Mental Illness/Substance Use Disorder	Los Angeles	For the substance use disorder target population, individuals had to have a substance use disorder and at least one of the following: 1) three or more ED visits related to SUD within the past year; 2) two or more inpatient admissions for physical and/or mental health conditions; 3) three or more sobering center visits within the past year; 4) homeless meeting HUD criteria; 5) part of foster system, 6) more than two residential SUD treatment admission within the past year, 7) history of two or more incarcerations with drug use, 8) drug court referral (to either Sentence Defender Court or Women's Re-Entry Court), and/or 9) history of overdose in the past two years.
	Mariposa (SCWPCC)	Individuals with a behavioral health conditions (mental health, substance abuse or co-occurring diagnosis) and one or more of the following: • Repeated incidents of emergency department (ED) use, hospital admissions or nursing facility placement • Two or more chronic conditions • Homeless or at-risk-of-homelessness (based on HUD criteria: people living in a place not meant for human habitation, in emergency shelter, in transitional housing, or exiting an institution where they temporarily resided) • Recently released from institutions (e.g., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system.
Homeless	Monterey	Homeless individuals under the HUD McKinney-Vento Homeless Assistance Act definition and the 2016 HUD Hearth definition of chronically homeless.

Target Populations	WPC Pilot	Target Population Criteria
	San Diego	Homeless individuals will be identified through the HMIS system or those who have recently accessed homeless services. At-risk individuals are determined if individuals are currently in an institutional setting, such as jail, a psychiatric hospital or other mental health facility, or a substance use residential or detoxification program. At-risk individuals will also include those currently in skilled nursing facilities who will not have stable housing at discharge.
Justice-Involved	Riverside	Probationers with the following criteria are targeted: • New probationers • On probation for at least one full year • At-risk of or experiencing homelessness • Have a behavioral health diagnosis • Have a physical health diagnosis

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.
Notes: ED is emergency department. HUD is the Department of Housing and Urban Development. SMI is serious mental illness. SUD is substance use disorder. SCWPCC is the Small County Whole Person Care Collaborative.

When asked to provide a rationale for selection of specific target populations in follow-up interviews, some Pilots reported broad and inclusive definitions to provide more flexibility in program implementation and to ensure they could meet projected enrollment goals.

> *"Very early on, we decided that the target population we wanted to serve would be individuals experiencing homelessness. There's been a lot of focus in our community and by our policymakers on people experiencing homelessness … [but] We have a history of … difficulty engaging with people experiencing homelessness in some of our other Health and Human Services programs… We weren't sure how much success we [were] going to have, whether we were going to be able to enroll enough people experiencing homelessness …, and so we left it [inclusion criteria] broad."*
>
> *–Placer*

Other Pilots developed more restrictive inclusion criteria with the intent of focusing services on specific population(s). For instance, Riverside exclusively targeted justice-involved, Mendocino exclusively targeted individuals with SMI, and Placer focused on the homeless.

Partnerships

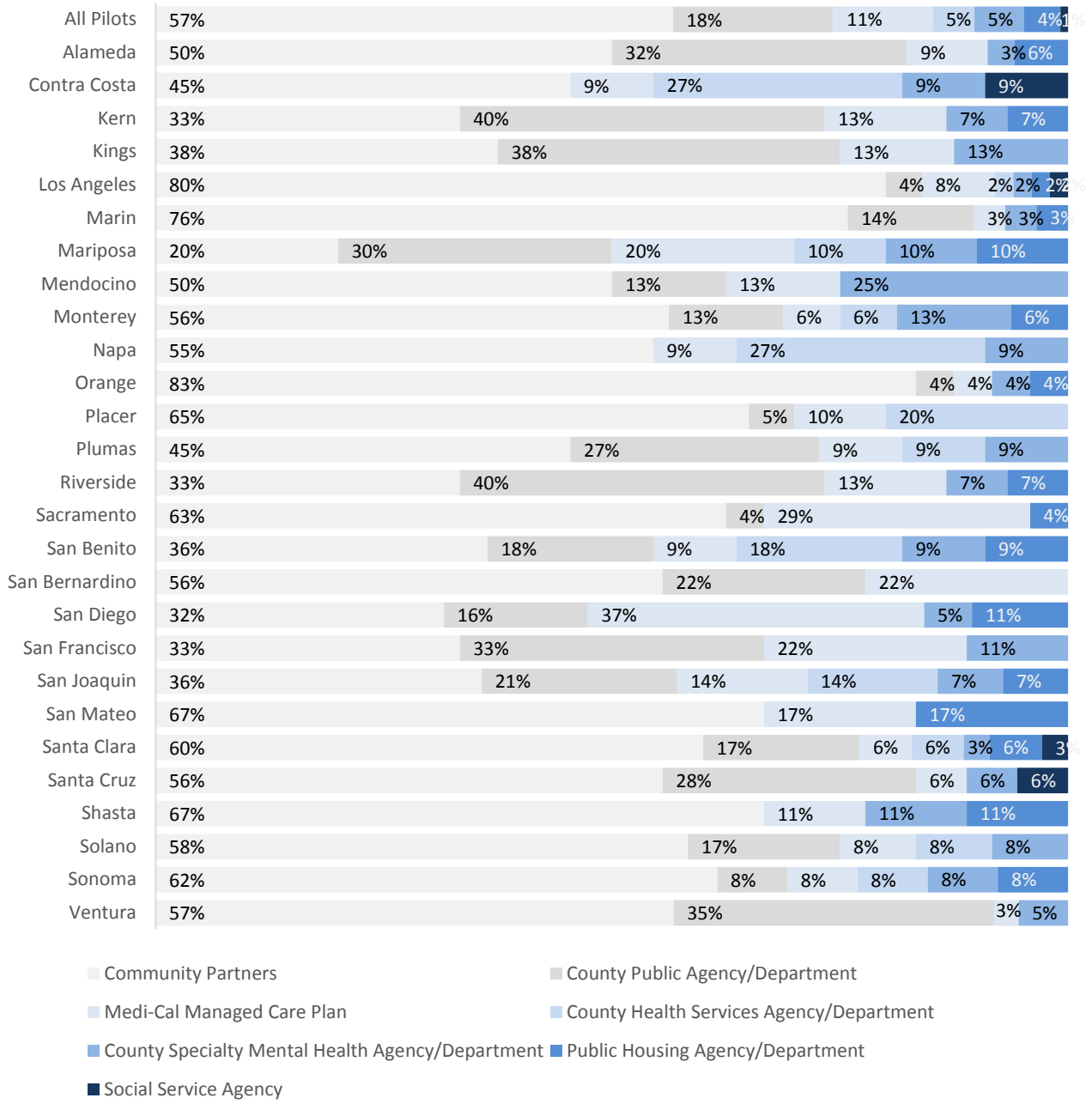
WPC Pilots were required to "increase integration among county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term." WPC Pilots were permitted to partner with as many organizations as they wished, but were required to include at least one Medi-Cal managed care health plan, one health services agency, one specialty mental health agency, one public agency, and two community partners.

Partner Selection and Decision to Participate

> *"The fact was [we're] a pretty small community, and that [what] we had to choose from, was pretty limited… and being an integrated agency… having internal partners was the easy thing to do as well."*
>
> *–Napa*

The choice of partners and their level of involvement varied significantly by Pilot and by type of partner organization. In their WPC applications, Pilots organized their partner organizations into pre-specified categories (Exhibit 17). On average, Pilots reported a total of 18 partners, ranging from a minimum of six partners to a maximum of 50. Overall, Pilots reported 478 total partners. Community partners comprised of 57% of all partner organizations; 18% were county public agencies; Medi-Cal managed care plans consisted of 11%; 5% were county specialty mental health services agencies; 5% were county health agencies; 4% were public housing agencies; and 1% were social services agencies.

Exhibit 17: Proportion of Types of WPC Partners by Pilot

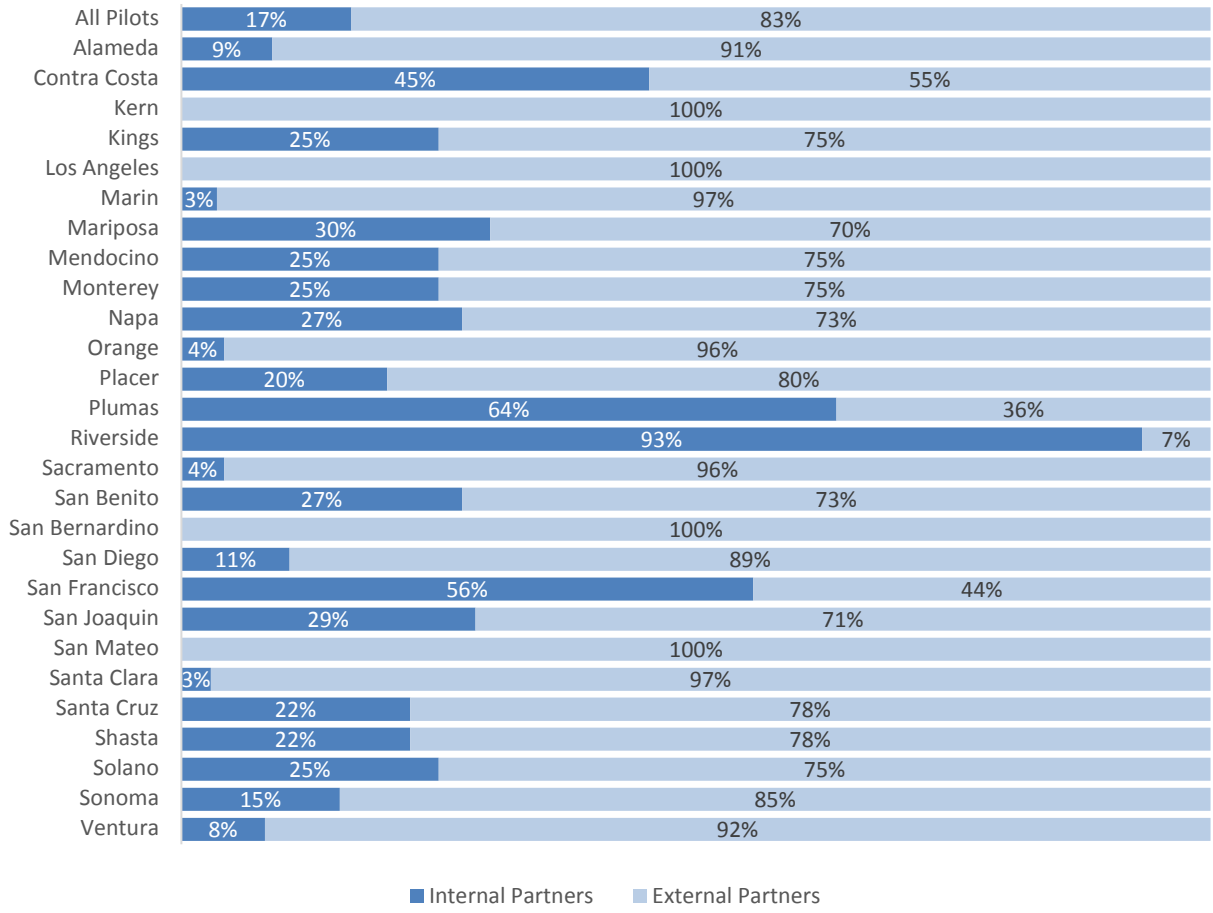


Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

Internal partners were defined as organizations that work under the same umbrella agency as the LE, such as the county hospital or county mental health department. External partners were defined as organizations outside the LE's umbrella agency such as health plans, community clinics, county probation/law enforcement, and housing service providers.

Based on the interim surveys, 17% of all partners were internal organizations and the remaining 83% were external organizations (data not shown). The distribution of internal and external partners varied considerably by Pilot. For example, almost all of Riverside's (93%, Exhibit 18) partners were internal, while all of Kern, Los Angeles, San Bernardino, and San Mateo's partners were external (100%).

Exhibit 18: Proportion of External and Internal Partners in WPC by Pilot



Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

Pilots described the role of each partner in their applications. Community Partners like Bay Area Community Service Center in Solano County provided social services and operated the largest homelessness program in the Bay Area. San Joaquin County Substance Abuse Services, a public agency, provided substance abuse treatment to individuals over 18 years old. Examples of specific partner organizations and their role in the WPC Pilot are provided in Exhibit 19.

Exhibit 19: Selected Examples of Specific WPC Partners, by Partner Type

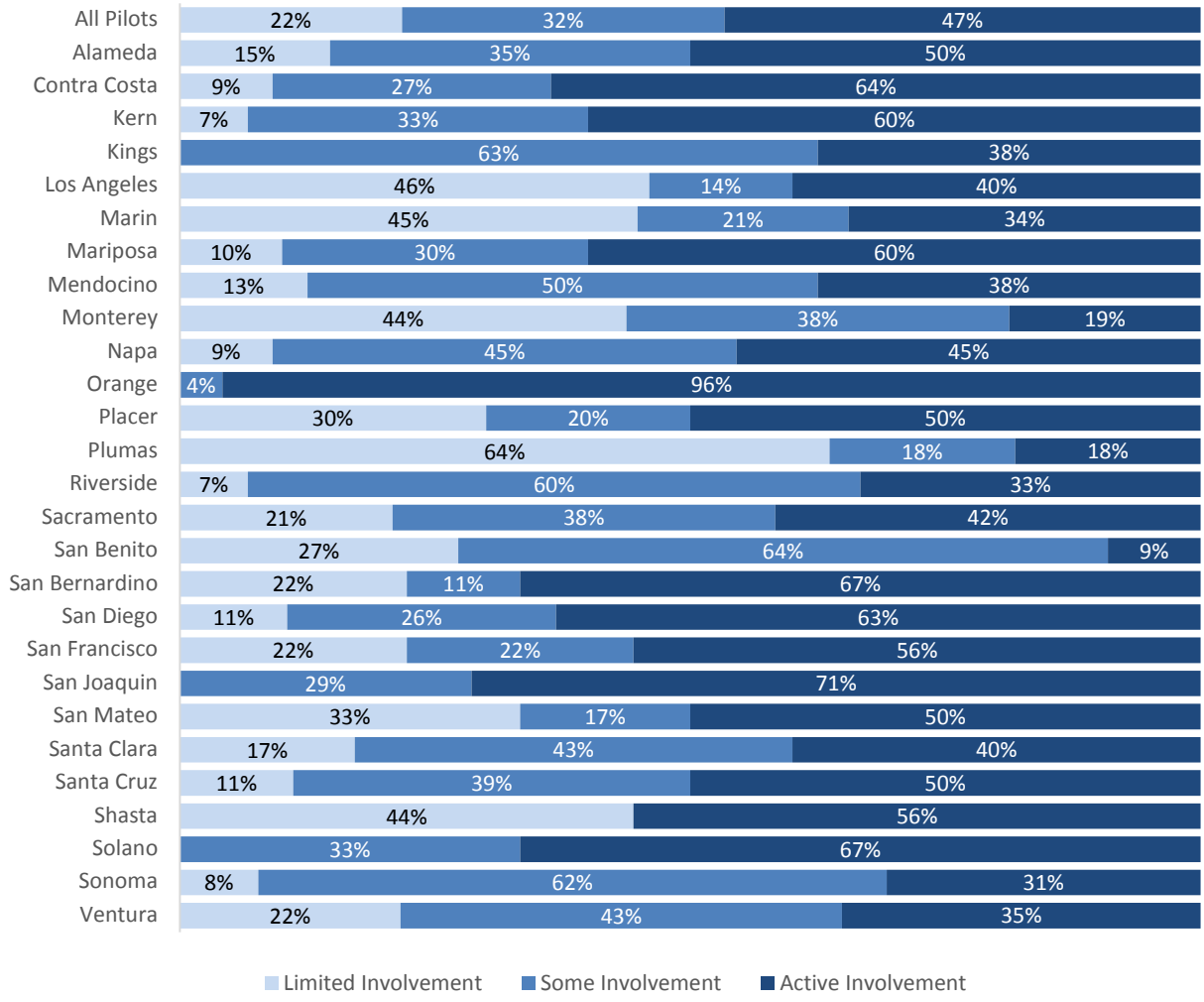
Type of Partner	Partner Name and Pilot
Community Partner	Bay Area Community Services (Solano) Elica Health Centers (Sacramento)
County Health Services Agency/Department	Contra Costa County Emergency Medical Services (Contra Costa) County of Santa Clara Public Health Department (Santa Clara) Health and Human Services: Placer County Public Health (Placer)
Medi-Cal Managed Care Plan	Central California Alliance for Health (Multiple) Anthem Blue Cross (Multiple) Alameda Alliance for Health (Alameda)
Other Public Agency/Department	Mendocino County Public Health Department (Mendocino) San Joaquin County Substance Abuse Services (San Joaquin)
Public Housing Agency/Department	Sonoma County Community Development Commission (Sonoma)
Specialty Mental Health Agency/Department	Ventura County Behavioral Health Department—Alcohol and Drug Programs (Ventura)
Social Service Agency	Encompass Community Services (Santa Cruz) Exodus Recovery (Los Angeles)

Source: Whole Person Care Pilot Applications (n=25), 2016.
Notes: DHCS required Pilots to have at least one Medi-Cal managed care health plan operating in the geographic area of the Pilots; one health services agency; one specialty mental health agency; one public agency (including county alcohol and substance use disorder program, human service agencies, or housing authorities); and two community partners. Community partners had to have significant experience serving the target populations with the participating Pilots.

Partners' Level of Involvement

Prior to fielding of the partner survey, Pilots were asked to categorize each partner's level of engagement with WPC by indicating if partners had: (1) limited involvement, e.g., only served as service provider or referral source and not involved in planning or decision-making related to WPC; (2) some involvement, e.g., in data sharing or stakeholder meetings, and (3) active involvement, e.g., in WPC planning and implementation. Data showed that 47% of partners across all Pilots were actively involved, 32% had some involvement, and 22% had limited involvement with WPC (Exhibit 20). The level of partner involvement varied across Pilots. For example, nearly all of Orange's partners (96%) were identified as actively involved, whereas Plumas (SCWPCC) identified the majority of partners (64%) as having only limited involvement in WPC.

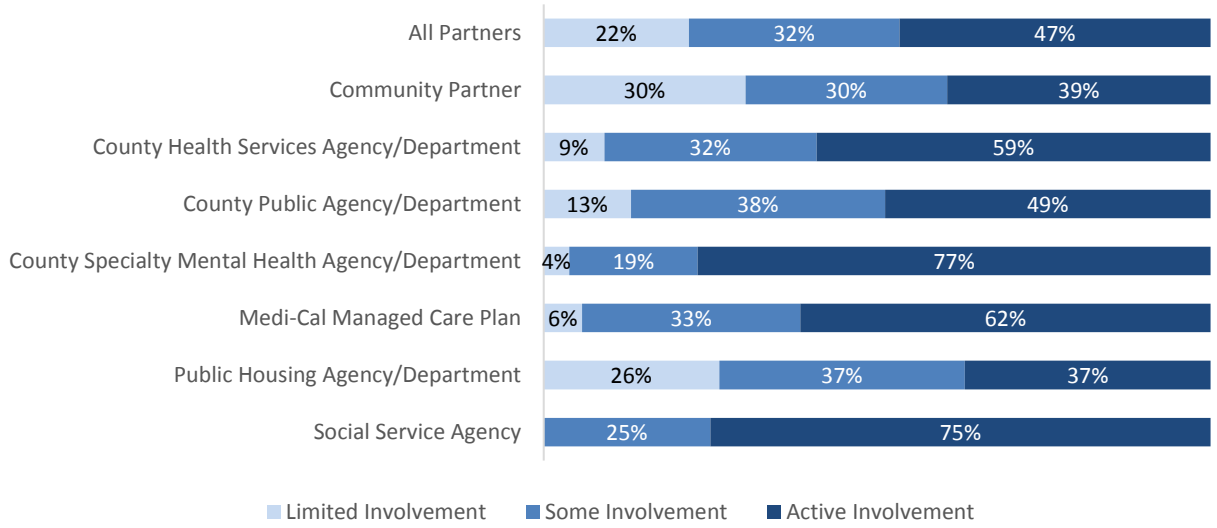
Exhibit 20: Level of Partner Engagement in WPC by Pilot, as Determined by Lead Entity



Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

Partners' level of involvement in WPC also varied by type of partner (Exhibit 21). The majority of county specialty mental health and social service agency partners were identified as actively involved with WPC (77% and 75% respectively) whereas the majority of community partners and public housing departments were identified as having only some or limited involvement in WPC (60% and 63% respectively).

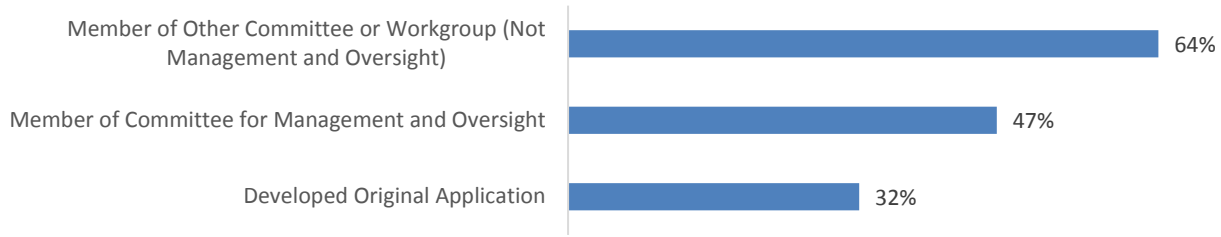
Exhibit 21: Level of WPC Partner Engagement by Sector



Source: Partners Entities by Sector as of September 2018 Reported from Lead Entities (n=486), August 2018-September 2018.

In the WPC interim partner survey, partners were asked to indicate ways in which their organizations were involved in WPC. The majority of partners reported being involved as members of a committee or workgroup that were not management or oversight committees/workgroups (64%) and 47% participated on a management or oversight committee (Exhibit 22). Partners were less commonly involved in the development of the original WPC application (32%).

Exhibit 22: Partner Organization Involvement in WPC by Overall Partner Organizations

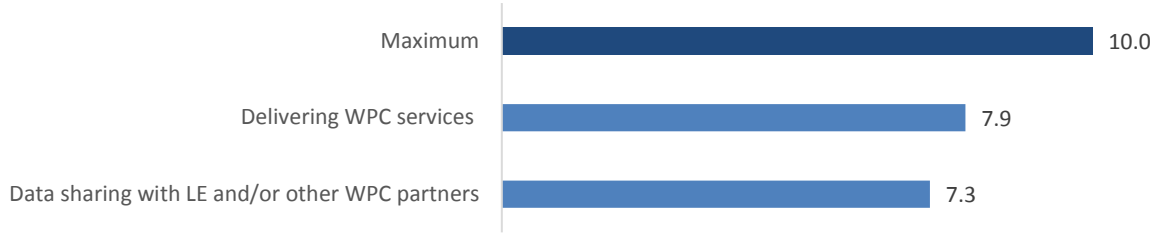


Source: Whole Person Care Partner Questionnaire (n=227), July-October 2018.

Based on results from the WPC partners, nearly half (44%) of partners participated in WPC meetings weekly or bi-weekly (data not shown). Participation in WPC meetings was greater among more involved organizations compared to less involved organizations. Similarly, more internal organizations participated in weekly or biweekly WPC meetings compared to external organizations.

WPC partners were asked to rate the level of effort required to implement certain WPC program activities from 0 (very low) to 10 (very high). Partner organizations indicated a greater level of effort was required in delivering WPC services (7.9) compared to sharing data with LE or other WPC partners (7.3, Exhibit 23).

Exhibit 23: Level of Effort Required to Implement the Following WPC Program Activities by Overall Partner Organization



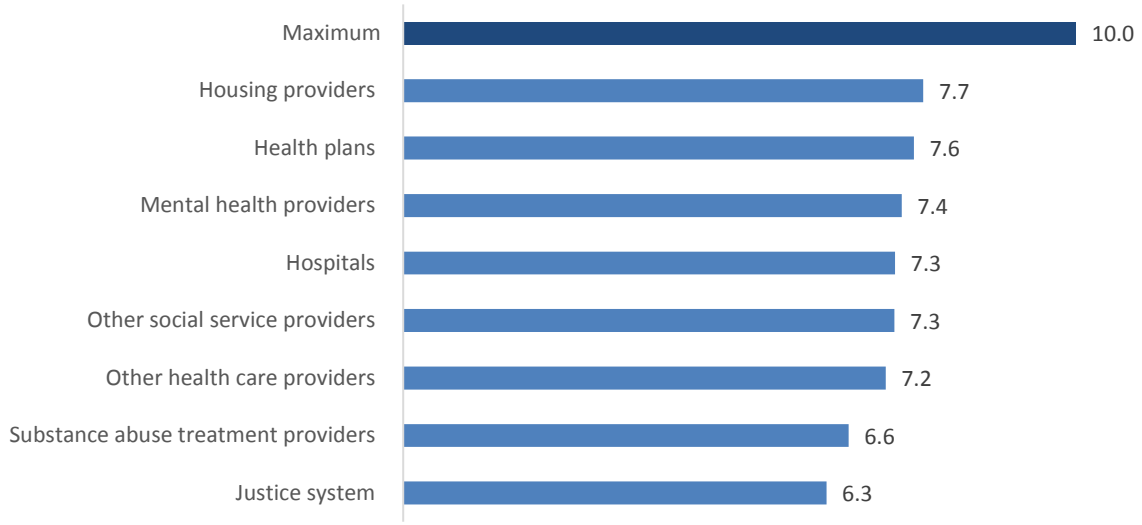
Source: Whole Person Care Partner Questionnaire (n=227), July-October 2018.
Note: LE is Lead Entity.

Pilots' Perception of Partner's Buy-in

In the survey, Pilots reported on their perceptions of partner buy-in for data sharing and care coordination by type of services these organizations provide. On a scale of 0 (very low) to 10 (very high), Pilots reported somewhat higher buy-in from housing providers (7.7) and health plans (7.6) than providers form justice system (6.3, Exhibit 24).

> *"Many of the people in the system have long held beliefs that they cannot share data despite updates to regulations and the existence of a client-signed consent for the release of information. It is necessary to constantly remain engaged at the front-line/person-to-person level to educate about what may and may not be shared."*
>
> *-Marin*

Exhibit 24: Average Rating of Buy-In for Data Sharing and Care Coordination by WPC Pilots Among Partners Distinguished by Type of Service



Source: Whole Person Care Pilot Survey (n=27), June-September 2018.
Notes: The providers in this exhibit are distinguished by type of service they provide. Sample sizes for justice system, substance abuse treatment providers, other health care providers, hospitals, and housing providers ranged from 21-26 as WPC Pilots could select "Not Applicable" when appropriate.

In follow-up interviews and mid-year and annual narrative reports, Pilots noted that these partnership gains required effort, and identified the inherent challenge in building fruitful relationships, such as partner staffing turnover and limited partner interest and buy-in that hindered partnership. For instance, San Diego emphasized how the level of engagement with partners required constant nurturing, and acknowledged flexibility and patience were required in working with partners to encourage buy-in. Specific examples of challenges and solutions related to partnerships buy-in are described in Exhibit 25.

Exhibit 25: Selected Examples of Challenges and Solutions to WPC Partner Buy-in

Challenges	WPC Pilot	Selected Examples
Data sharing	Alameda	The majority of Alameda's partners expressed skepticism about data sharing due to concerns around protecting enrollees' privacy. Alameda emphasized the need to demonstrate the benefits of coordinating care and assuring partners that data systems were established to protect enrollee data.
	Kern	Kern experienced privacy and technological capabilities issues in providing relevant information to appropriate partner agencies. The implementation of the electronic data warehouse was expected to allow an enhanced ability to provide regular data updates, and give a clearer picture of beneficiaries to community partners.
	Mendocino	Care coordination in Mendocino was burdened by communication overload by directly connecting with partner organizations. Partner agencies emphasized the need for a more sustainable and systematic approach such as a care management platform to work collaboratively.
Communication	San Bernardino	Partner engagement was a challenge in San Bernardino due to high staff turnover and changes in policy across partner organizations. San Bernardino noted the need for constant communication in order to gain successful partnership collaboration.
	Sonoma	Sonoma emphasized establishing engagement with FQHCs was an ongoing process and that it took roughly six months to establish relationships strong enough to establish workflows and referral pathways.
Partner goals and roles	Santa Cruz	Santa Cruz indicated there was confusion among both internal and external partners on partner roles, responsibilities, and purpose of committee meetings, resulting in meeting burn-out.
	Mendocino	Mendocino stated it was necessary to have a greater understanding of partner goals and capabilities in order to encourage meaningful engagement and understand partner roles within WPC.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.

Pilots also described some successes in increasing partner engagement and buy-in. In follow-up interviews, Pilots discussed meeting partners where they were at and developing compromises with the understanding partner agencies have competing priorities. Specific examples of successes related to partnership buy-in and engagement are described in Exhibit 26.

"We have worked to identify additional programs throughout the community that can be leveraged to directly benefit WPC beneficiaries, and we have also been successful at compromising and finding working solutions with our partners."

-Kern

Exhibit 26: Selected Examples of Partnership Buy-In Successes Among WPC Pilots

WPC Pilot	Selected Examples
San Diego	Continued discussions with partners around HIPAA and updating MOUs as needed increased transparency and clarity among partners sharing data.
Kern	Increased collaboration between partner county agencies, health plans, and community based organizations occurred in Kern due to the impact of WPC. As a result of the improved engagement, Kern has identified additional programs that can be leveraged to identify solutions and compromises for partners.
Kings	The leadership of King's steering committee improved engagement among county agencies, health plans, and other partner organizations. Partner roles increased and decision-making have been expedited as a result.
Riverside	Integrating WPC screening nurses in probation offices improved engagement among probation and housing partners significantly. Having the nurse stationed at the probation office facilitated communication and relationship building with cross-sector partner organizations.
Santa Cruz	Santa Cruz went on a "road show" to meet with partner agencies to gain a better understanding of their programs and services to WPC enrollees. This resulted in increased buy-in from partners by opening communication channels and additional opportunities to collaborate.
San Joaquin	San Joaquin established a bi-weekly operations meeting with partner agencies in order to build shared understanding of partner agency roles, responsibilities, and objectives in order to reduce duplication of services and getting involved in others' responsibilities.
Sonoma	The WPC team meets with the multidisciplinary team on a weekly basis to discuss care coordination amongst the Sonoma County safety net agencies. During these meetings, case managers and care team members from the various agencies discuss the enrollees who are seeking services and discuss strategies in this intimate setting to expedite care for the clients. The care team helps locate clients, identify potential referral or service opportunities, upcoming appointments or deadlines, and other opportunities based on the clients' needs. This group has been extremely successful getting clients in supportive housing, on general assistance programs, supporting upcoming court dates, and getting clients into treatment.
Marin	Marin General Hospital has invited the homeless service providers to monthly meetings with their behavioral health, care coordination, and social work unit supervisors to improve communication and ultimately, successful discharges for these enrollees.
Monterey	Monterey implemented monthly meetings with core partners that helped to build understanding between partners' various scopes of work, enhance communications, and streamline workflow.

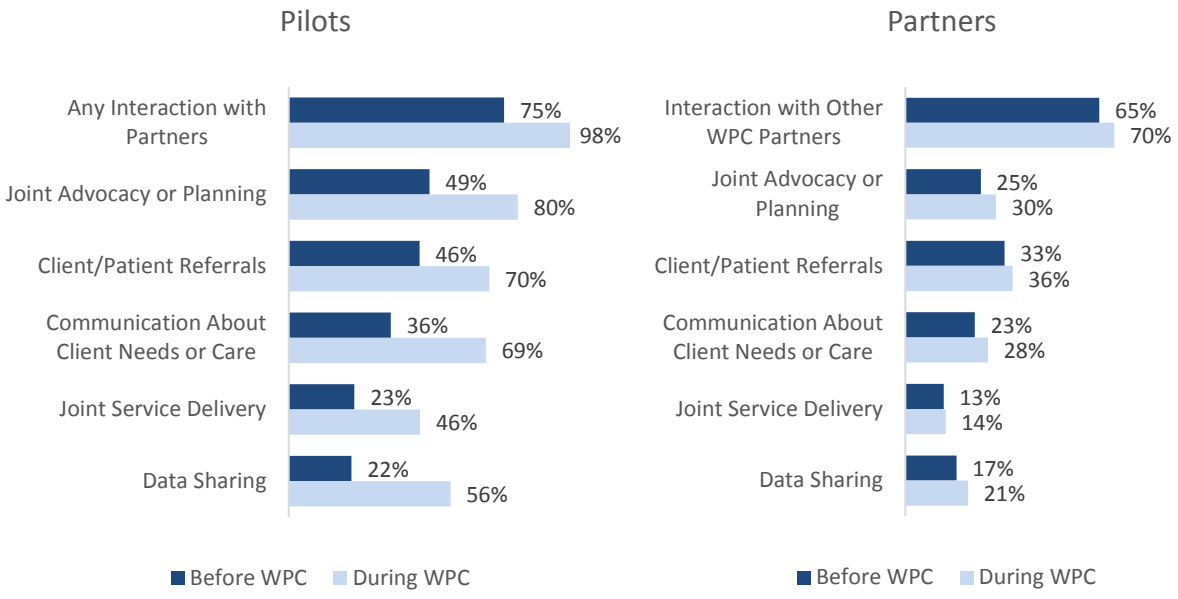
Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports.
Notes: HIPAA is Health Insurance Portability and Accountability Act. MOU is Memorandum of Understanding.

Perceived Impact of WPC on Cross-Sector Collaboration and Integration of Care

In the interim survey, Pilots reported on their relationship with each participating WPC partner before and after implementation of WPC. Similar questions were asked of partners in the partner survey. Pilots reported some prior collaboration with most partners (75%) prior to WPC and an increase in interactions during WPC (98%, Exhibit 27). When asked about specific interactions, Pilots reported significant increases during WPC in joint advocacy and planning (80%), referrals (70%), and communication about clients (69%). Partners reported an increase in interaction with other partners after WPC (from 65% to 70%) and increases in similar activities as Pilots.

> *"Transparency is critical to maintaining these partnerships. Ongoing engagement has been a goal. So, we try to make sure that everybody has an opportunity to participate in our governance structure. We have a newsletter where we post all of our materials, so that somebody who has missed the meeting can always see what's happening."*
>
> *– Sacramento*

Exhibit 27: Type of Interaction with Partners Before and During WPC Implementation Among WPC Pilots and Partners



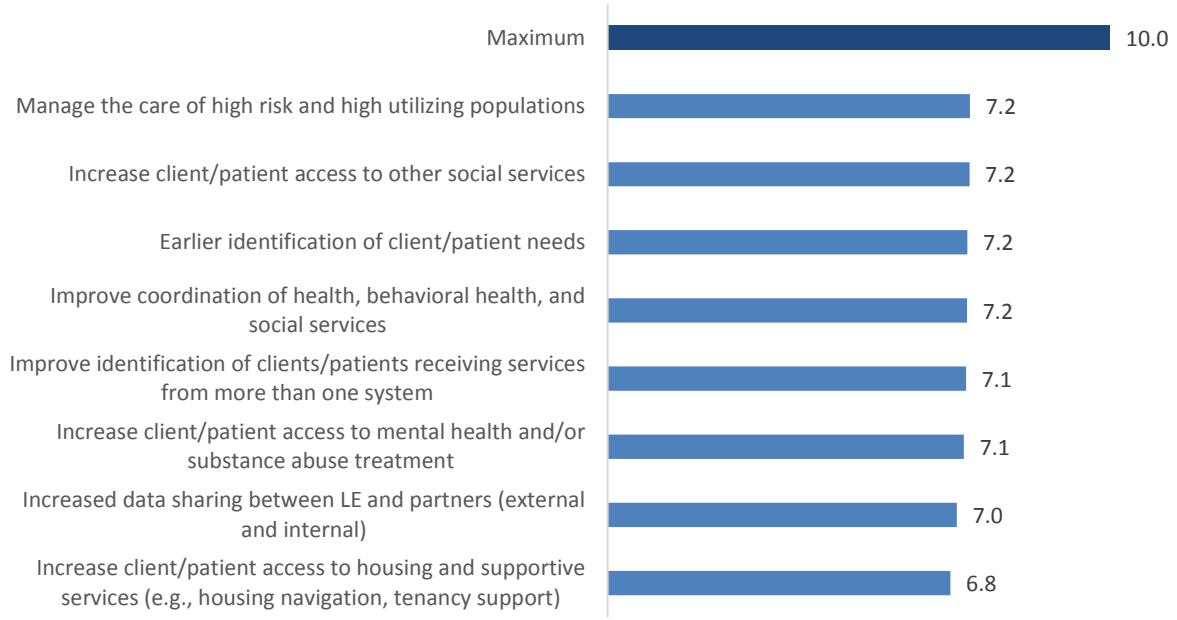
Sources: Whole Person Care Pilot Survey (n=27), June-September 2018 and Partner Survey (n=227), July-October 2018.
Note: Partner survey included partners actively involved or with some involvement and excluded partners with limited involvement.

During follow-up interviews, Pilots reported that WPC provided an important opportunity to develop and/or enhance working relationships with partners. Improved communication and stronger relationships with partners following WPC were often attributed to time spent better

understanding how their respective organizations worked, and due to Pilot investment in data sharing and care coordination.

In the partner survey, partners rated how effective the WPC program has been at achieving goals from 0 (not effective) to 10 (extremely effective). On average, partners rated relatively high effectiveness of WPC managing the care of high-risk, high-utilizing populations (7.2) and in improving the coordination of health and social services (7.2, Exhibit 28).

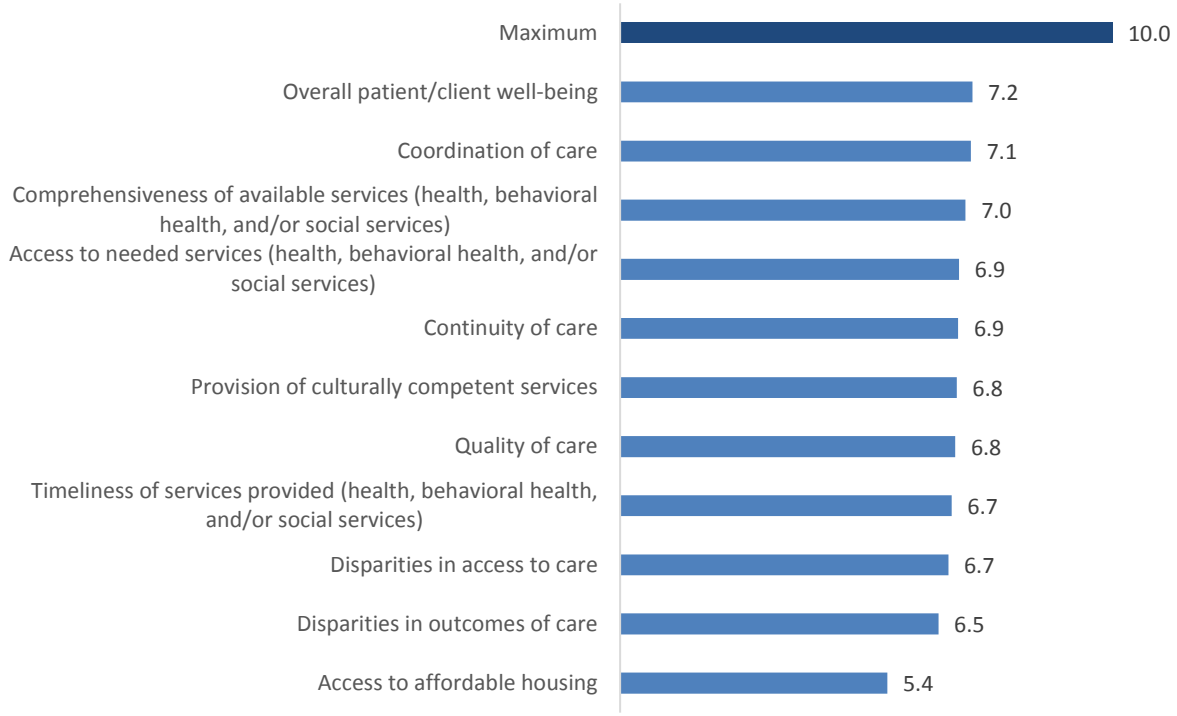
Exhibit 28: Partners' Perceived Effectiveness of WPC in Achieving Goals



Source: Whole Person Care Partner Survey (n=227), July-October 2018.
Note: Partner survey includes partners actively involved or with some involvement and excluded partners with limited involvement. Sample size for selection of goals ranged from 167 to 179 as partner organizations could select "unknown" when appropriate.

Partners also indicated the extent to which WPC improved aspects of care delivery to clients/patients from 0 (not at all) to 10 (very much). On average, organizations rated WPC's effectiveness in improving the coordination of care (7.1) and overall patient/client well-being (7.2) relatively similarly (Exhibit 29).

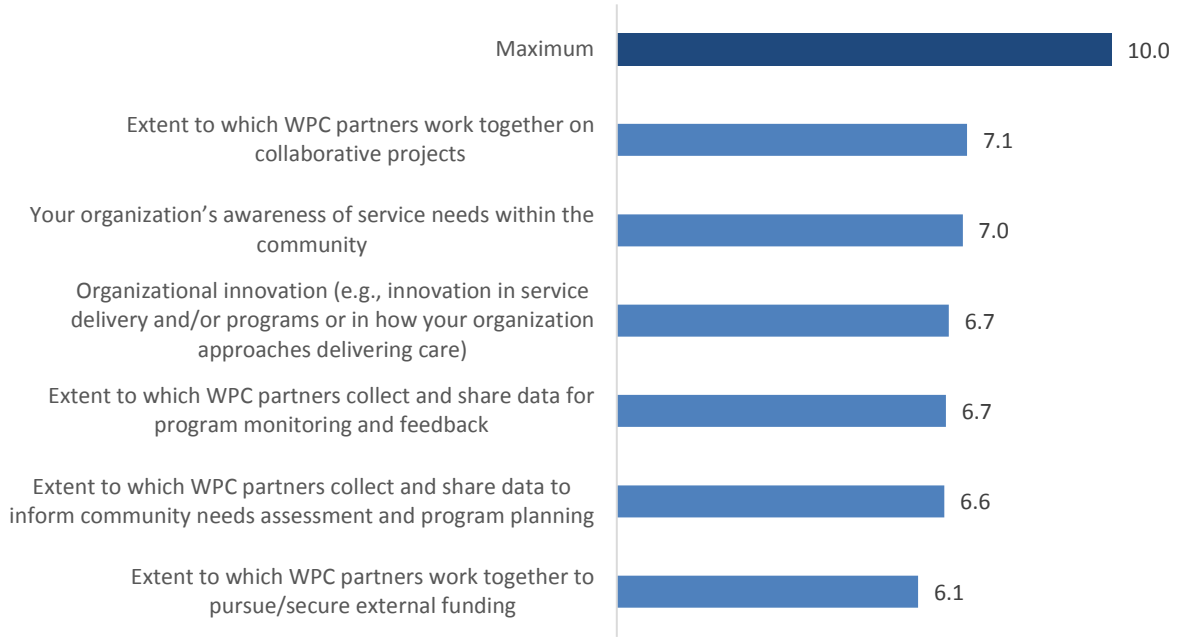
Exhibit 29: Partners' Perceptions of Improvements in Aspects of Care Delivery Due to WPC



Source: Whole Person Care Partner Survey (n=227), July-October 2018.
Notes: Partner survey includes partners actively involved or with some involvement and excluded partners with limited involvement. Sample size for selection of areas ranged from 140 to 170 as partner organizations could select "Unknown" when appropriate.

Partners further indicated the extent to which WPC improved collaboration and other interactions with partners from 0 (not at all) to 10 (very much). On average, partners rated WPC's effectiveness in improving how partners work together on collaborative projects (7.1), followed by awareness of community's needs (7.0, Exhibit 30).

Exhibit 30: Partners' Perceptions of Improvement in Collaboration and Other Partner Interactions Due to WPC



Source: Whole Person Care Partner Survey (n=227), July-October 2018.
Notes: Partner survey includes partners actively involved or with some involvement and excluded partners with limited involvement. Sample size for selection of areas ranged from 130 to 185 as partner organizations could select "unknown" when appropriate.

Chapter 5: Health Information Technology and Data Sharing Infrastructure

WPC Pilots were required to "improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion". This chapter addresses the following evaluation questions: "to what extent did the Pilot (a) improve data collection and information sharing amongst local entities to support identification of target populations, ongoing case management, monitoring, and strategic program improvements in a sustainable fashion; and (b) achieve the approved application deliverables relating to data collection and information sharing?" and "what key factors aided or hindered the success of specific strategies in implementing or achieving the intended outcomes, and what measures are WPC Pilots taking to address these barriers?"

In their initial applications, WPC Pilots were required to describe: (1) how data would be shared with and between participating partners, (2) methodology for sharing Protected Health Information (PHI), particularly mental health, and/or substance use disorder information, (3) use of tools to support data sharing, and (4) timeline and implementation plan for developing the data sharing infrastructure. Furthermore, WPC Pilots were required to collect data for analysis and reporting in order to assess WPC program interventions and enrollee health and care outcomes. WPC Pilots were allowed to adjust already existing processes, identify new and existing data systems, and integrate new tools to improve data collection and reporting.

Data sources for this chapter included interim Pilot surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots. Additional qualitative data around challenges and solutions was provided in 25 WPC mid-year and annual narrative reports. For additional detail on data sources and methodology please see Appendices C, D, and E.

Data Sharing Infrastructure

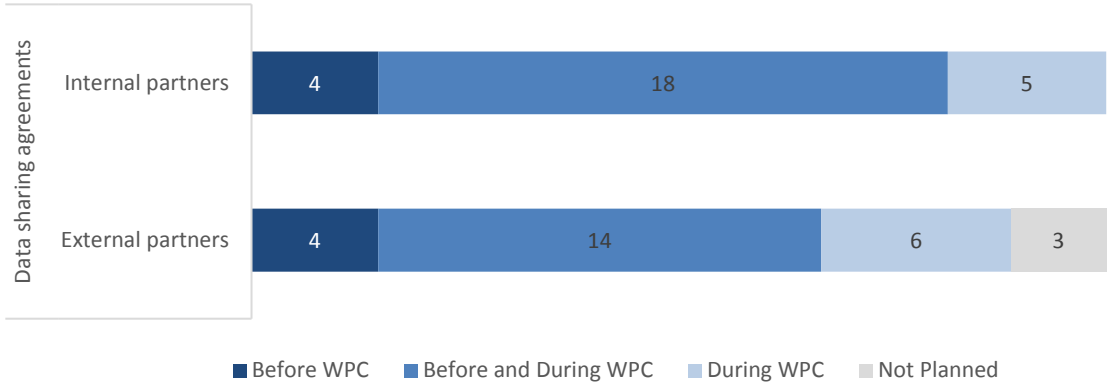
As indicated in the Care Coordination Policy Brief and Pilot Case Studies, effective cross-sector care coordination required timely sharing of information among the care coordination team and providers. Data sharing infrastructure that facilitated this type of information exchange included (1) formal agreements that defined terms and conditions of data sharing with key partners; (2) a universal consent form to reduce barriers to sharing patient data; (3) use of an electronic data sharing platform that includes key information such as comprehensive care plans; (4) medical, behavioral health and social service use data and (5) capacity to track and report care coordination activities. Ideally, care coordinators could also access this data sharing system to (6) view and enter data (7) remotely (e.g., in the field) and (8) in real-time. [1], [2], [3]

Data Sharing Agreements and Enrollee Consents

Data sharing agreements, Memorandums of Understanding (MOUs), and Business Associate Agreements (BAAs) were formal mechanisms used to facilitate data sharing amongst Pilots and their partners (i.e., across organizations). These agreements typically ensured accountability to Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements and created liability between the participating parties.

During WPC, overall engagement in the use of data sharing agreements, MOUs, and/or BAAs with both internal and external partners increased (Exhibit 31). As indicated in the interim survey, many Pilots had already established some degree of data sharing agreements, BAAs, and/or MOUs with partners before WPC. Many of those Pilots who had existing agreements expanded or planned to expand through WPC with both internal and external partners (18 of 27 and 14 of 27, respectively). During WPC, several Pilots implemented or planned to implement new data sharing agreements, BAAs, and/or MOUs with internal and external partners (5 and 6, respectively).

Exhibit 31: Number of Pilots Participating in Data Sharing Agreements, MOUs, and/or BAAs with Internal and External Partners, Before and During WPC



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.
Notes: In the interim survey, UCLA asked about data sharing with internal and external partners separately due to the organizational barriers inherent in data sharing related to infrastructure and accessibility. Internal partners were defined as organizations that worked under the same umbrella agency as the LE, such as the county hospital or county mental health department. External partners are defined as organizations outside the LE's umbrella agency such as health plans, community clinics, county probation/law enforcement, and housing service providers.

During follow-up interviews, data sharing agreements were often described by Pilots as time-intensive to successfully implement for WPC due to a wide variety of Pilot-specific challenges. For example, Pilots expressed difficulty working with some partner organizations that did not actively promote a data sharing culture and reaching agreement amongst participating parties on appropriate language for formal contracts. Furthermore, the organizational structure of a Pilot could either facilitate or hinder data sharing processes required for the Pilot, as it was often easier to share data within an umbrella organization than outside one's own agency.

Additionally, enrollee consent was required to share private health data amongst care providers and participating partner organizations. Pilots took a wide variety of approaches to the development of consent forms, which often accompanied the process of enrolling into the program. Some Pilots implemented a segmented consent form, which allowed enrollees to choose which types of data they felt comfortable sharing; for instance, this segmented consent form provided the option for enrollees to consent to share medical history, but not SUD patient records.

Exhibit 32 provides selected examples of how Pilots implemented various data sharing agreements and enrollee consent forms to support WPC activities.

Exhibit 32: Selected Examples of Data Sharing Agreements and Enrollee Consent in WPC

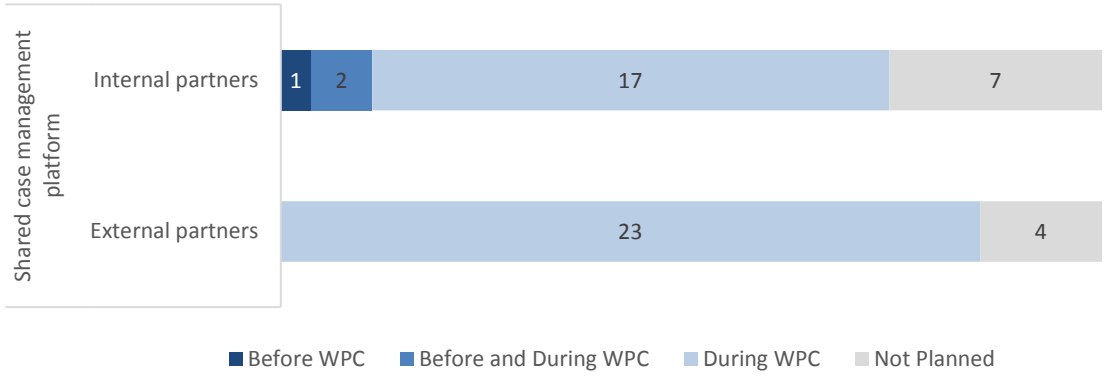
WPC Pilot	Selected Examples
Santa Cruz	In Santa Cruz, many Data Use Agreements (DUAs) and Business Associate Agreements (BAAs) existed prior to WPC because of the county's health information exchange. This previously established infrastructure facilitated data sharing for WPC care coordination activities.
Contra Costa	During initial WPC engagement, prospective enrollees signed (1) a consent for treatment form, which covered data sharing amongst all agencies within the comprehensive health system (e.g., behavioral health, public health, emergency medical services, and housing) and (2) a universal release form, modeled from an existing program in Contra Costa, which allowed the Pilot to share data amongst external and internal partners.
Kings	Enrollees in Kings signed a universal release of information that allowed the care team to discuss an enrollee with all of King's WPC partners. Separate releases of information were needed when an enrollee utilized other community resources provided by non-WPC partners (such as the emergency shelter).
Los Angeles	Los Angeles required partners to sign a business associate agreement with a data-sharing element. Enrollees were required to sign a universal consent form in order to participate in WPC, which was segmented to allow enrollees to opt-out of sharing particular data elements, such as data covered by the Code of Federal Regulations (CFR) Part 2, mental health history, and/or HIV test results. The universal consent authorized Los Angeles to share data for a five-year period, even after disenrollment or graduation from the WPC program.
Mendocino	Enrollees in Mendocino signed a release of information form that was developed collaboratively by all partnering agencies.

Source: Follow-up Interviews with Lead Entity and Frontline Staff (n=27), September 2018-March 2019.

Availability of Case Management Tools

During WPC, overall use of a shared electronic case management platform increased with internal and external partners (Exhibit 33). In the interim survey, only three of 27 Pilots indicated having a shared case management platform with internal partners before WPC, while no Pilots had a case management platform with external partners before WPC. However, the great majority of Pilots implemented or had plans to implement a shared electronic case management platform with internal partners (17 of 27) and external partners (23) during WPC.

Exhibit 33: Number of Pilots Participating in a Case Management Platform with Internal and External Partners, Before and During WPC



Notes: In the interim survey, UCLA asked about data sharing with internal and external partners separately due to the organizational barriers inherent in data sharing related to infrastructure and accessibility. Internal partners were defined as organizations that worked under the same umbrella agency as the LE, such as the county hospital or county mental health department. External partners were defined as organizations outside the LE's umbrella agency such as health plans, community clinics, county probation/law enforcement, and housing service providers.

During follow-up interviews, many Pilots reported that they acquired and/or developed a case management platform to facilitate daily workflows and ensure appropriate capture and tracking of important patient data such as demographic characteristics, encounter notes, and attempts to contact. The majority of case management platforms were intended to be web-based, which would allow the care coordination team to access enrollee data and case notes in the field and when working directly with the enrollee. Exhibit 34 provides selected examples of how case management software and real-time data sharing facilitated care coordination activities. Additional detail and examples around data sharing infrastructure for care coordination is presented in the Chapter 8: Care Coordination.

Exhibit 34: Selected Examples of Case Management Software and Real-time Data Sharing in WPC

WPC Pilot	Selected Examples
Alameda	Alameda utilized an existing tool called "EDie" to notify and alert frontline staff in real-time when WPC enrollees had an emergency department encounter.
Contra Costa	Care coordinators in Contra Costa received real-time notifications when WPC enrollees visited the emergency department or an in-patient setting at any hospital within the local geographic area.
Kings	Kings adopted a care coordination platform called ETO from Social Solutions. ETO allowed the care team to input case notes, record care coordination services, and build reports.
Los Angeles	Los Angeles developed their case management platform "CHAMP", which facilitated workflows for frontline staff by providing eligibility screenings, enrollment documentation and assessments, stores enrollee documents (i.e., universal consent form) and care plan, and comprehensively documents case related information (e.g., attempted contacts with enrollees, case notes). Throughout the Pilot, Los Angeles made continuous improvements and

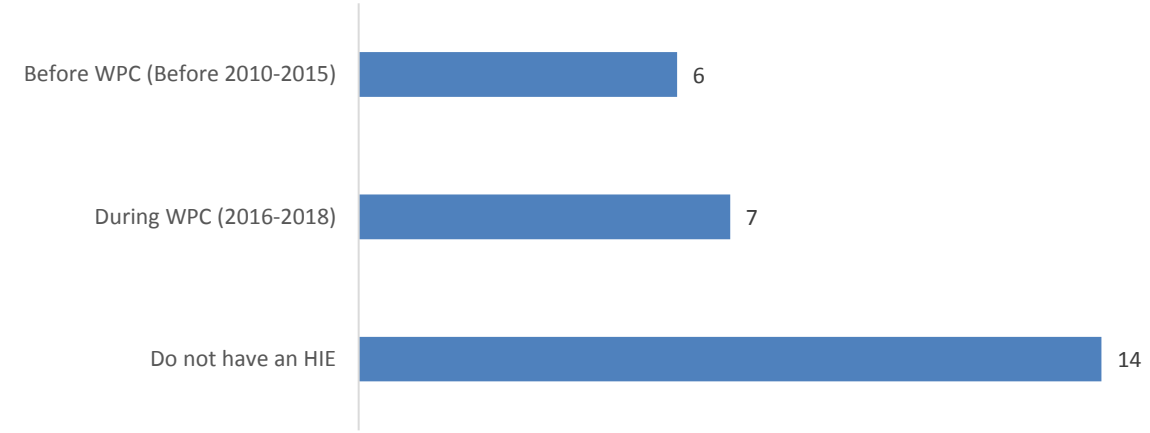
WPC Pilot	Selected Examples
	modifications to the platform based on user-feedback. There were over 1,800 individual users on "CHAMP" and each individual's access was based on their unique role (e.g., treating providers could see mental health and substance use disorder data). The end goal for "CHAMP" was to be an "integration hub" that collected and shared data across Los Angeles County; functionality of the platform had been a continuous area for improvement.
Marin	Marin's care coordination platform went live in October 2018 and was viewed as a critical tool for allowing the care coordination team to stay up to date about an enrollee's current goals, appointments, progress, and future scheduling. Communication amongst the care team could occur through in-platform messages or through a chat function.
Orange	Orange launched "WPC Connect," their care coordination platform, in December 2018. Prior to this, data sharing between partner organizations occurred by phone or email. WPC Connect provided access and data sharing to all partner organizations and care coordination providers. WPC Connect could also store and share the structured care plan with providers, see if previous points of contact by partners organizations had been established with the individual, enroll the patient, and see what services were being provided to the patient.
Sacramento	Sacramento's "Pathways Portal" was a real-time data sharing platform and allowed each member organization of each of the three service hubs (Sacramento Covered, housing partners, and health partners) to see all information on each client. The Pathways Portal online shared care plan included data on referrals, goals, concerns, acuity level, interventions, and a client profile.

Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

Health Information Exchanges

Health information exchanges (HIE) electronically store and move clinical information among different health care information systems within a region, community, or hospital system. In the interim survey, 13 WPC Pilots (48%, Exhibit 35) reported that they participated in an HIE. Of these, six Pilots had participated in 2015 prior to the start of WPC. One Pilot started as early as before 2010. During 2017 (PY 2), three Pilots started participation in an HIE and in 2018 (PY 3), four Pilots started participation (data not shown).

Exhibit 35: Year When Pilot First Began Participating in a Health Information Exchange

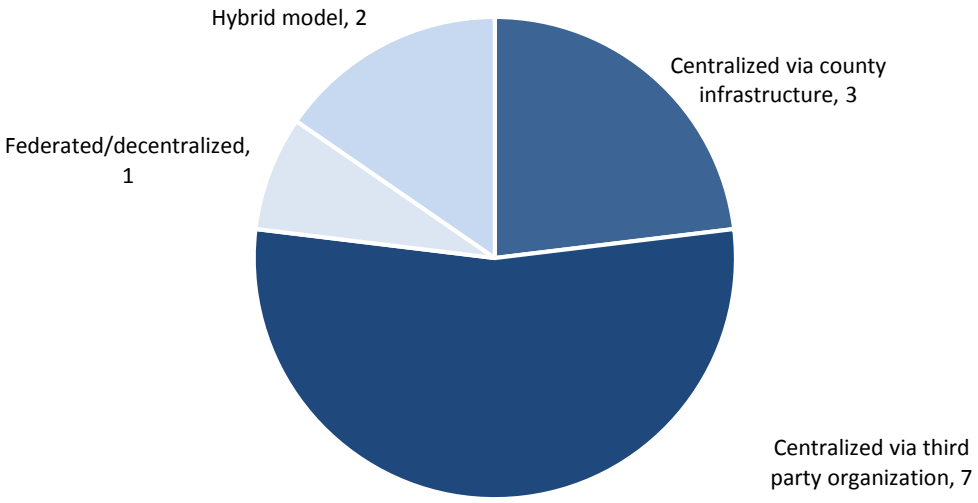


Source: Whole Person Care Pilot Interim Survey, n=27.

HIEs have been stored and centralized through a variety of models. The most common models that were being used were a centralized model, hybrid model, a decentralized model, and a centralized model through a third party organization [4], [5]. In the interim survey, Pilots reported different approaches to centralization of data in their HIEs.

Seven Pilots (54%) reported their HIE was centralized via a third-party organization that stored all the data in a single data warehouse or data repository to be used by partners as needed (Exhibit 36). Three WPC Pilots reported their HIE was centralized internally and access was given to partners as needed. Two Pilots reported a hybrid model where some data was stored in a centralized repository and some data was not. One Pilot reported a decentralized structure, where all data stayed at the point of service and sharing data was at the discretion of participating organizations.

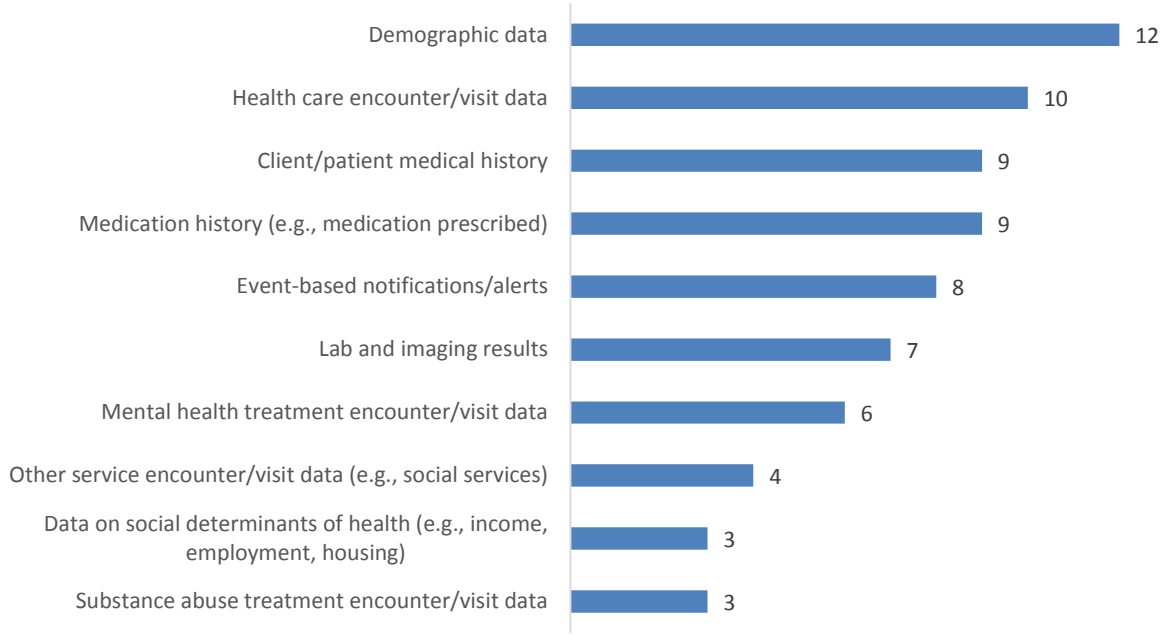
Exhibit 36: Centralization of Health Information Exchanges Among WPC Pilots



Source: Whole Person Care Pilot Interim Survey, n=27.
Notes: Seven Pilots had an HIE centralized via third party organization (Los Angeles, Monterey, Riverside, San Bernardino, San Joaquin, San Mateo, and Santa Clara), three Pilots had an HIE centralized via county infrastructure (Alameda, Contra Costa, and Marin), two had a hybrid model (Placer and San Diego), and one Pilot had a federated/decentralized model (Santa Cruz).

The comprehensiveness of data in HIEs varied by WPC Pilots (Exhibit 37). Twelve Pilots had demographics data most commonly available (92%), and nine had health care encounter/visit data (69%). Three Pilots had substance abuse treatment encounter/visit data less commonly available (23%) and three had other data on social determinants of health (23%).

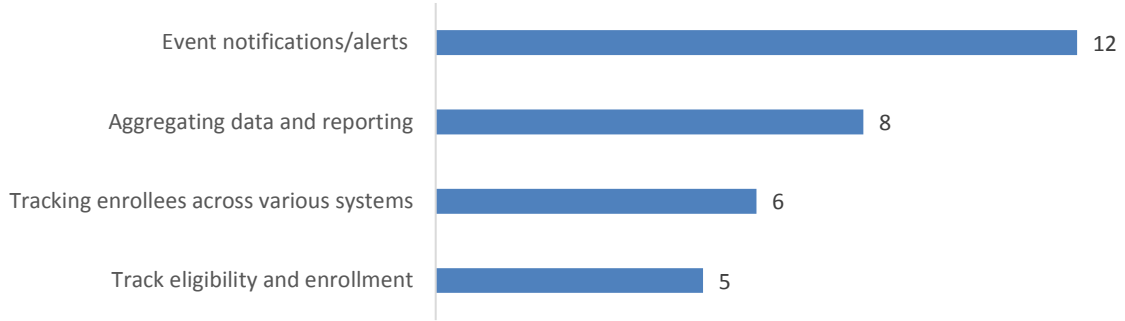
Exhibit 37: Comprehensiveness of Data in Health Information Exchanges under WPC



Source: Whole Person Care Pilot Interim Survey, n=27.
Notes: Only includes those Pilots who participated in an HIE (n=13).

Pilots reported on specific functionality of their HIE and 12 Pilots (92%) reported having event notifications and alerts to primary care provider or care coordinator upon hospital discharge (Exhibit 38).

Exhibit 38: Pilots on Functionality of HIE under WPC

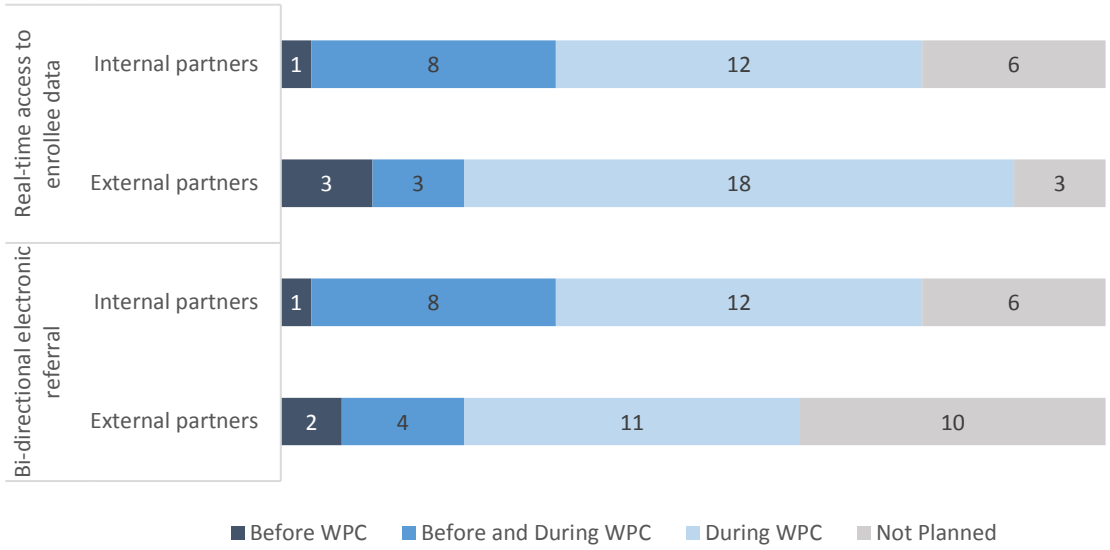


Source: Whole Person Care Pilot Interim Survey, n=27.
Notes: Only includes those Pilots who participated in an HIE (n=13). WPC Pilots' response to question: "Does the HIE under WPC have the following functionalities? (Select all that apply)".

Data Sharing Processes

Use of data for real-time decision making and referrals increased through WPC (Exhibit 39). In the interim survey, nine of 27 Pilots indicated real-time access to enrollee data with internal partners and six Pilots indicated real-time access to enrollee data with external partners before WPC. Through WPC, 12 and 18 Pilots indicated newly accessing real-time data with internal and external partners, respectively. Similarly, there has been an increase in the use of bi-directional electronic referrals. Please reference the Chapter 8: Care Coordination for additional detail on data sharing processes to support care coordination.

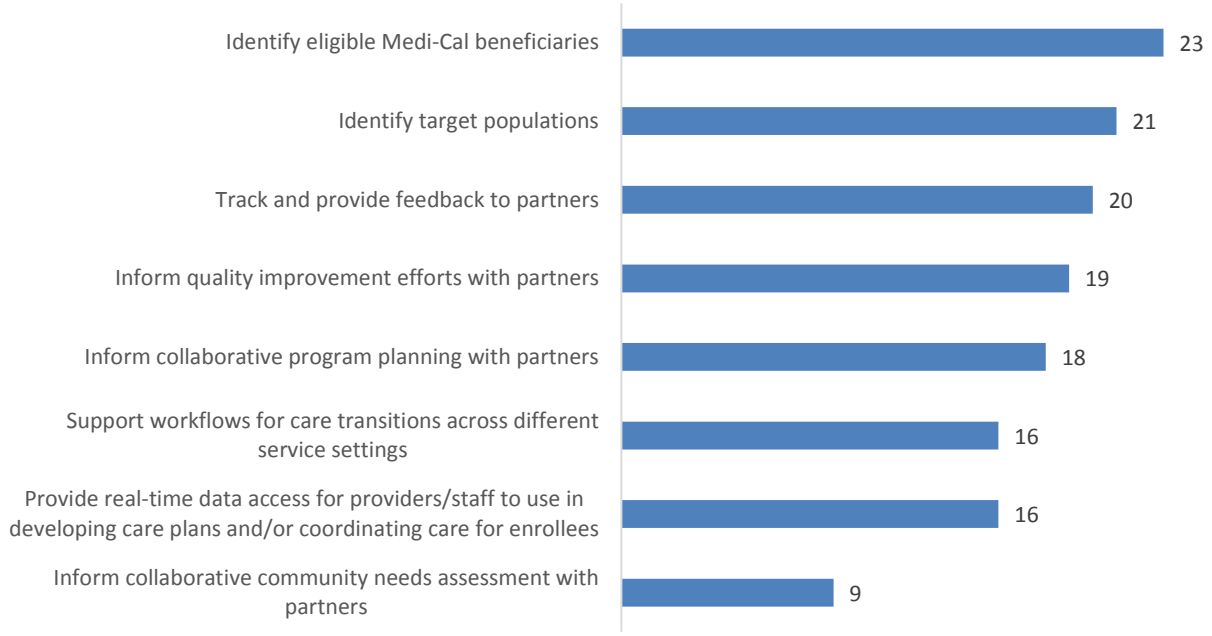
Exhibit 39: Number of Pilots Participating in Data Sharing Activities with Internal and External Partners, Before and During WPC



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

WPC Pilots shared data for a multitude of purposes and the tools needed to share data varied greatly across Pilots. In the interim survey, Pilots were asked the most common uses of shared data: 23 Pilots reported to identify eligible Medi-Cal beneficiaries (85%), 21 Pilots reported to identify target populations (78%), and 20 Pilots to track and provide feedback to partners (74%, Exhibit 40). Only 59% of Pilots (16) provided real-time data access for providers and staff to use in developing care plans and/or coordinating care and/or used shared data to support care coordination workflows across different service settings.

Exhibit 40: How Pilots Used Shared Data as Part of WPC



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

> *"We've committed to the technology being in one system, which is huge for a county our size... I think Whole Person Care, PRIME, and the Global Payment Program, to some extent, have allowed us to really make that a reality."*
>
> *–Contra Costa*

As emphasized in follow-up interviews with leadership and frontline staff, Pilots had a wide variety of existing infrastructure in place prior to WPC. Further developing and pursuing opportunities to develop new health information infrastructure were frequently identified as strategic priorities of WPC Pilots. Exhibit 41 outlines selected examples from follow-up interviews of how Pilots have utilized or plan to utilize health information technology and data sharing as part of WPC, illustrating both the range of functionality of health information technology and the methods used for data sharing across Pilots.

Exhibit 41: Selected Examples of Health Information Technology and Data Sharing in WPC

WPC Pilot	Selected Examples
Alameda	Alameda emphasized how bringing different data systems together from housing, training and development, and health provided an opportunity to evaluate provider performance and use that information to target specific partners and providers for more intensive monitoring and engagement, particularly around performance metrics.
Kern	Kern began developing an electronic data warehouse that would allow them to better understand the WPC population and make data needed for effective care coordination accessible to all organizations involved in the enrollee's care.

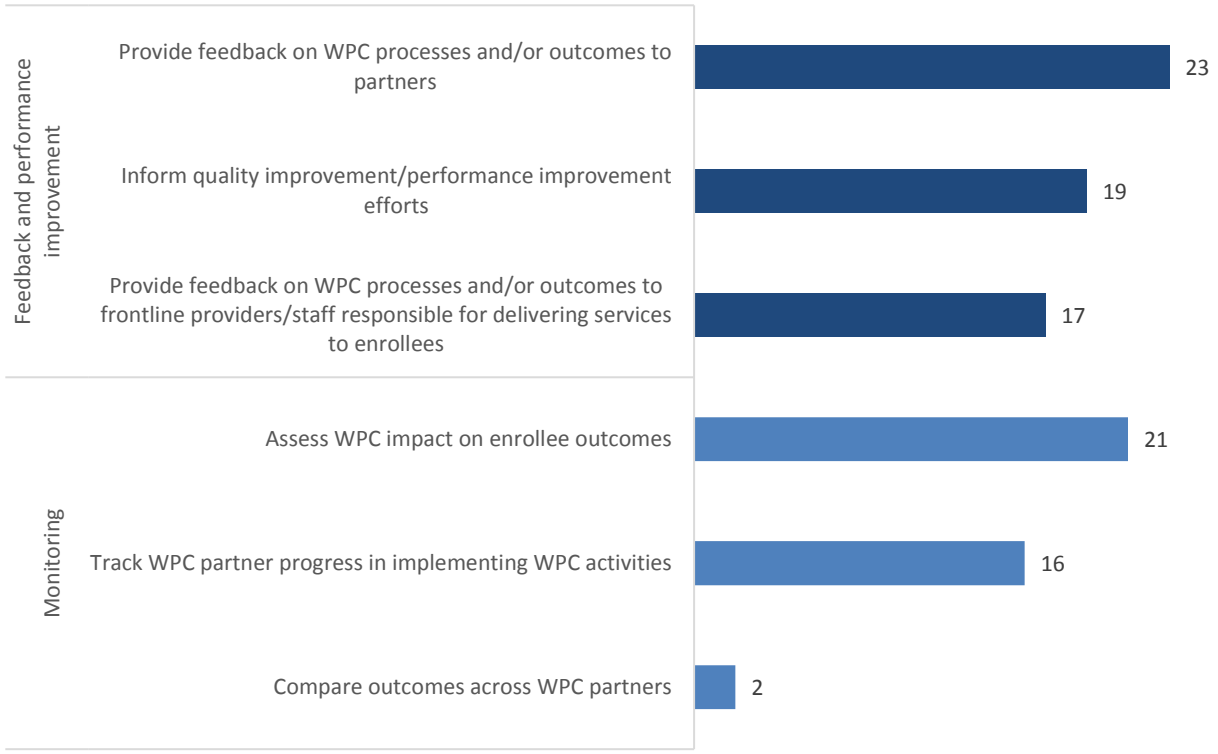
WPC Pilot	Selected Examples
Mendocino	Mendocino implemented a document/data-sharing platform called ShareFile, for sharing documents amongst participating partners such as enrollment forms, care plans, care conferencing notes, and releases of information. All partners were provided logins and access to the system.
Monterey	Monterey developed an "Enterprise Master Patient Index" to match medical records from different sources, thereby allowing the Pilot to combine enrollee data across organizations.
San Bernardino	San Bernardino developed an algorithm to identify potential WPC enrollees. Once created, the enrollee list was downloaded to a population management platform that the WPC teams could access. Within the platform, teams could send one another to-do lists, develop care plans, and store notes on their enrollees' care needs and services.
San Francisco	The Pilot shared data through the coordinated care management system, an integrated social and health information database of clients from the San Francisco County Public Health Department. This system existed since 2003 and combined client data from over 15 sources; WPC aimed to expand functionality. Providers could enter data directly into the database, and the system included summary pages for each client. This existing infrastructure supported WPC care coordination by ensuring that providers had access to both enrollee health and social information.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

Performance Monitoring

In the interim survey, Pilots reported on how they monitored performance under WPC and whether they used their findings to improve performance. Twenty-three Pilots reported they monitored performance and provided feedback on WPC processes and outcomes to partners (85%, Exhibit 42). Twenty one Pilots also assessed WPC impact on enrollee outcomes (78%); and nineteen informed quality improvement/performance improvement efforts (70%).

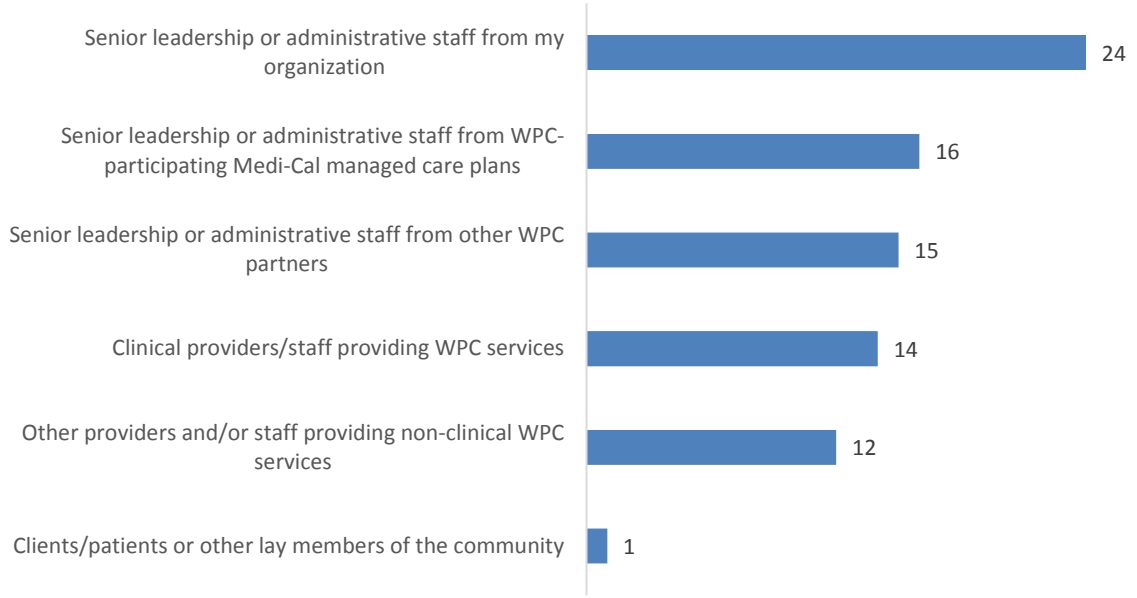
Exhibit 42: How Pilots Are Using Metrics Being Collected as Part of WPC



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

Pilots also reported on specific groups of stakeholders who received the WPC required performance metrics that were reported to DHCS. Twenty-four Pilots shared this information with administrative staff from the Lead Entity (89%, Exhibit 43). Fewer shared this information with partners of other staff.

Exhibit 43: Dissemination of and Feedback on Performance Metrics Within WPC Pilots



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

In follow-up interviews, 16 WPC Pilots reported they were tracking additional metrics (data not shown). There was variation amongst Pilots in the additional metrics being tracked (Exhibit 44). Some examples of additional measures included: program performance measures, screenings and referrals, utilization of health services including emergency care, utilization of social services including housing, arrests and incarcerations, online portal and app usage, social needs, demographics, and financial data. Tracking Medi-Cal churn was noted as particularly useful for maintaining WPC enrollment.

Exhibit 44: WPC Pilots and Selected Examples of Tracking Additional Measures Outside Required Metrics to State

WPC Pilot	Selected Examples
Alameda	Alameda monitored monthly output metrics to better understand partner's efforts. Alameda used data (e.g., high no-show rates) to identify provider's relative strengths and weaknesses, which has allowed Alameda to target specific providers with relatively poor performance. From the Pilot's perspective, this has provided an opportunity for more meaningful engagement.
Contra Costa	Contra Costa tracked the following metrics related to program implementation: screening and referral to services; no-show rates; enrollee usage of MyCCLink (an online portal for patient records); enrollee usage of advice nurse/appointment line; Medi-Cal churn; tracking of social needs; and costs of patients to healthcare systems. These measures were tracked by discipline, tier, and demographics to better understand the WPC enrollee population.
Kings	Kings tracked the following metrics related to program implementation: screening/referral timeframes, employment statistics, housing statistics, completion of enrollee stated goals, and number of linkages to resources. Many of these measures were designed to monitor contracts and partner progress.

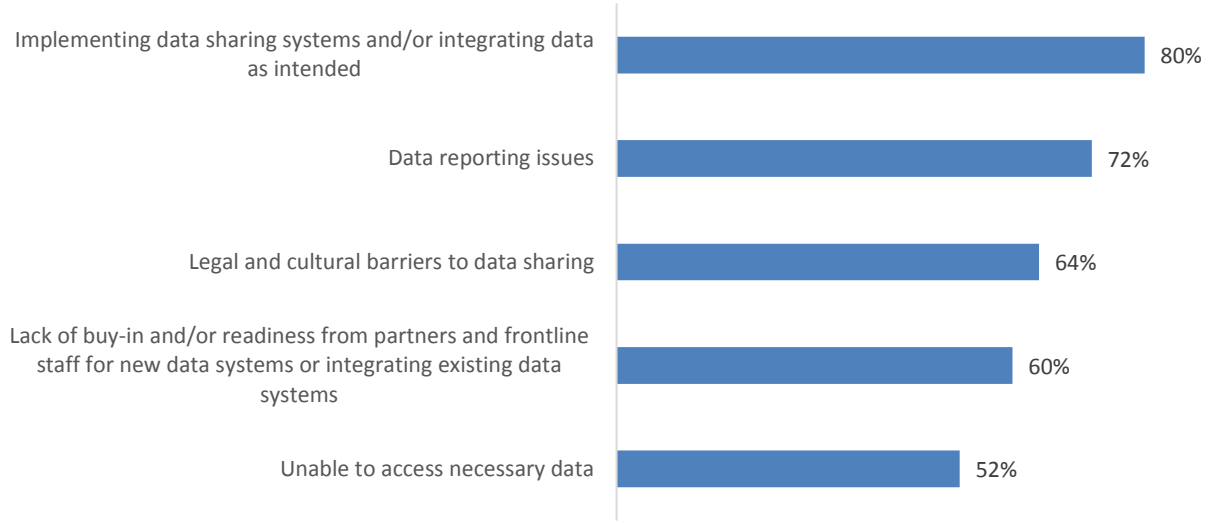
WPC Pilot	Selected Examples
Los Angeles	Los Angeles actively monitored caseloads for frontline staff and Medi-Cal coverage rates among the population. Additional measures related to program implementation included: 30-day supply of medication, housing placements, transportation provided, and appropriate identification/documentation secured.
Marin	Marin tracked changes in emergency medical services transports and arrests and incarcerations per year; Marin calculated the reduction in costs associated with each of these metrics.
Mariposa (SCWPCC)	Mariposa believed that their elderly and medically fragile clients are not living long past 65; therefore, the Pilot actively monitored the number of clients over the age of 60 and tracked housing supports and referrals to services for these clients.
Riverside	Riverside actively monitored each referral made at screening and whether the individual made it to their appointment.
San Benito (SCWPCC)	Recognizing the small size of their program, San Benito noted that difficulty interpreting the metrics reported to the state (e.g., particularly susceptible to skewness). San Benito created several more meaningful measures to understand their program, such as tracking the amount of time spent with each client to better understand resource allocation and staff capacity.
San Diego	Contractors in San Diego shared weekly progress reports which included success stories and enrollment numbers. This system helped San Diego monitor progress and identify best practices across teams.
Shasta	Shasta monitored demographics for the WPC population to understand any relevant program-level trends.

Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.
Note: SCWPCC is the Small County Whole Person Care Collaborative.

Challenges and Solutions

In narrative reports, 20 WPC Pilots (80%) reported inability to implement data sharing systems and/or integrate data as intended as a barrier to data sharing (Exhibit 45). WPC Pilots noted that data sharing often required integrating data from disparate sources. For example, frontline staff had to assimilate data from different electronic health records or administrative databases so they could comprehensively understand the needs of an enrollee in order to make an informed care decision on what the enrollee required. Vendor delays, designing and/or purchasing technology that allowed for real-time data storage, and access by multiple agencies and users were described as challenges, both in terms of cost and in terms of the identification and selection process.

Exhibit 45: Data Sharing Challenges Among WPC Pilots, January 2017-December 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports (n=93).
Notes: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the four reports.

Almost three-fourths of WPC Pilots (72%, 18) reported issues with data reporting including tracking care coordination activities and services provided through WPC. Multiple WPC Pilots reported challenges in ensuring consistency of data being collected across partners; WPC Pilots noted a considerable effort to reconcile different data sources and develop new documentation strategies.

Many WPC Pilots (64%, 16) identified legal and cultural barriers to data sharing such as risk aversion, differing interpretations of laws and regulations. Fear of violating the Health Insurance Portability and Accountability Act or other data privacy laws was cited as contributing to a reluctance to share data, even across departments within the same agency. WPC Pilots described misunderstandings and differing interpretations among partners regarding what data could be legally shared as a barrier to successful data sharing. In particular, roughly one-third of WPC Pilots (36%, 9) explicitly referenced privacy restrictions under Title 42 of the Code of Federal Regulations (CFR) Part 2 as complicating efforts to share substance abuse treatment data, and necessitating development of new referral, intake, and/or consent forms (data not shown).

Over half of WPC Pilots (60%, 15) discussed challenges around a lack of buy-in and/or readiness from partners and frontline staff for new data systems or integrating existing data systems. Many partners had different and very particular data needs and it was challenging to find a platform that met everyone's specifications. Frontline staff were resistant to access multiple

systems in order to input required information for reporting and tracking of care coordination services.

Lastly, 13 Pilots (52%) expressed difficulty with ability to access necessary data for WPC implementation. The majority of these Pilots did not have real-time access to Medi-Cal coverage which would be useful in verifying prospective enrollee's eligibility and preventing unnecessary churn from Medi-Cal and the WPC program. Selected examples of challenges related to each main category in Exhibit 45 are described in Exhibit 46.

Exhibit 46: Selected Examples of Data Sharing Challenges Among WPC Pilots, January 2017-December 2018

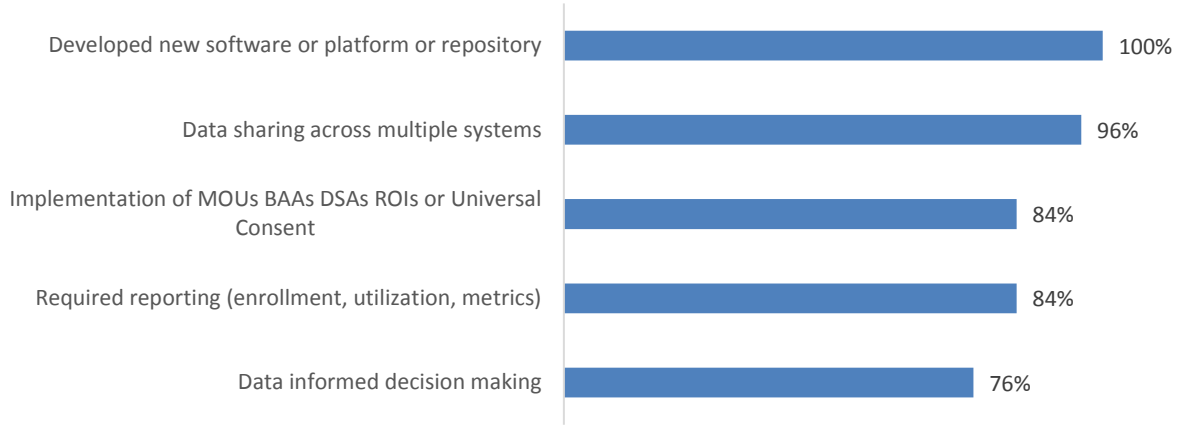
Challenge	WPC Pilot	Selected Examples
Implementing data sharing systems and/or integrating data as intended	Solano	Solano underestimated the amount of time it would take to study available options and choose a data sharing platform that would best fit the Pilot; as a result, enrollment began without a formal structure to collect enrollee data.
	Kern	Kern expressed challenges identifying a data sharing platform that would work well with external partners, while simultaneously integrating with their own "antiquated" EHR. Kern Medical Center was in the process of selecting a new EHR; as a result, Kern delayed commitment to a stand-alone care management system with hopes they could strategically think about integrated capabilities in the future.
	Mendocino	Mendocino faced challenges with their ShareFile platform; the platform was more difficult to use than anticipated and did not provide real-time data and as such, providers were not incentivized to participate.
Legal and cultural barriers to data sharing	Alameda	Alameda noted a general culture of concern amongst partners about information sharing, privacy, and confidentiality restrictions. This greatly inhibited partners' willingness to collaborate and consider innovative solutions for care coordination issues.
	Napa	Napa underwent significant negotiation and strategized with county privacy and security staff to access the data needed to coordinate care for the Pilot's enrollees and adequately report metrics.
	Marin	Marin emphasized long-held beliefs amongst participating partners on why they could not share data despite having a client signed release of information, which authorized the data sharing.
Data reporting issues	San Francisco	San Francisco faced challenges with effectively capturing and tracking complex care coordination encounters by a wide range of providers due to technical and administrative issues. Many providers had to manually complete paper encounter forms, which was then dependent on the safe transport, digitization, and storage of physical encounter forms containing private health information. Inconsistent

Challenge	WPC Pilot	Selected Examples
		data entry and a manual data process limited San Francisco's ability to report accurately.
	Kings	Partners in Kings faced competing priorities for time and resources and often considered metric reporting to be of low importance; as a result, metrics were reported to the Pilot somewhat sporadically.
	Sacramento	Sacramento faced challenges with data aggregation as partners submitted service data in multiple formats. As a result of issues with the aggregation process, Sacramento underreported in their initial submission of the PY 3 enrollment and utilization report, resulting in a new data quality review process and re-submission of the report.
Lack of buy-in and/or readiness from partners and frontline staff for new data systems or integrating existing data systems	Riverside	Riverside had multiple data systems to track and document services; nurse case managers were often required to look at up to three different systems in order to view complete records, demonstrating lack of readiness for data integration.
	San Mateo	Systems of care across the San Mateo health system use various electronic health records and case management systems for the same enrollees with no clear communication pathways across the systems.
	Alameda	Alameda emphasized how partners demonstrated differing degrees of buy-in depending on level within the organization (e.g., frontline staff were more supportive of data sharing than strategic leadership).
Unable to access necessary data	Santa Cruz	Santa Cruz experienced difficulty obtaining historical and valid Medi-Cal coverage dates which made it difficult to analyze metrics and automatically check enrollee Medi-Cal coverage in real-time.
	San Mateo	San Mateo expressed restricted access to Medi-Cal eligibility, Homeless Management Information System (HMIS), and client level substance use disorder data, which resulted in challenges for managing Medi-Cal churn and appropriately coordinating enrollee care.
	Los Angeles	Los Angeles emphasized their inability to verify Medi-Cal coverage.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports (n=93).
Notes: EHR is electronic health record.

All 25 WPC Pilots reported solutions in working towards developing a new software, platform, and/or repository (Exhibit 47). This may have included: developing a new care management platform, utilizing temporary data systems while longer-term solutions were still being developed, moving forward with procurement processes for data systems, and/or expanding functionality within existing systems including developing additional forms and prompts within EHR.

Exhibit 47: Commonly Identified Solutions in Data Sharing, Information Technology, and Reporting Among WPC Pilots, January 2017-December 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports (n=93).
Notes: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the four reports. MOU is Memorandum of Understanding. BAAs are Business Associate Agreements. DSA is Data Sharing Agreement. ROI is Release of Information.

Twenty four WPC Pilots (96%) reported solutions in sharing data across multiple systems, particularly with Medi-Cal managed care organizations, local homeless management information systems, substance use disorder programs, and county behavioral health departments (Exhibit 47). When available technology infrastructure or regulatory permissions did not permit electronic sharing of data across multiple partners, several WPC Pilots identified in-person data sharing as a "workaround". For example, during in-person meetings, frontline staff would have the opportunity to share hard copies of important documents and details of important interactions and conversations they had with the enrollee.

A total of 21 WPC Pilots (84%) identified solutions related to implementing data sharing agreements (e.g., MOUs, BAAs) and consents with WPC partners. Many WPC Pilots found data sharing agreements and universal consents to be the foundation necessary for effective referral pathways and truly coordinated care.

Twenty one WPC Pilots (84%) also reported solutions in meeting external reporting requirements. For example, WPC Pilots ensured timely submission of enrollment and metrics from partners. Oftentimes, WPC Pilots were reliant on partners to collect the necessary data, a process which was subject to confusion and inconsistency on how to appropriately calculate metrics. WPC Pilots were able to overcome these problems by working with partners to ensure standardized reporting of outcome metrics (e.g., Pilots developed and encouraged partners to use specific templates to submit their data).

Nineteen WPC Pilots (76%) reported using data informed decision making to support implementation processes or quality improvement efforts. For example, WPC Pilots utilized high risk notifications when enrollees checked into ED, and provided dashboards to frontline staff to help track enrollee progress on relevant metrics. This data allowed frontline staff and management to make real time strategic and informed decisions regarding enrollees' care. Selected examples of successes related to each main category in Exhibit 47 are described in Exhibit 48.

Exhibit 48: Selected Examples of Solutions in Data Sharing Among WPC Pilots, January 2017-December 2018

Solution	WPC Pilot	Selected Examples
Developing a new software, platform, and/or repository	Los Angeles	Los Angeles implemented a new care management platform, "CHAMP", which allowed the care coordination team to capture enrollment data, track enrollee encounters, and create/modify each enrollee's comprehensive care plan.
	Mendocino	Mendocino and many of their partners were awarded a community grant to implement the case management system called Vertical Change. Implementation was planned for early 2019.
	Orange	In PY 3, Orange implemented a new software called WPC Connect, which transitioned WPC staff away from manual data collection and reporting. WPC Connect provided a direct eligibility feed from CalOptima, one of their managed care plans.
Data sharing across multiple systems	Kern	Kern successfully partnered with their sheriff's department for data sharing to identify eligible Medi-Cal enrollees and locate them upon release from incarceration. The sheriff's department provided the Pilot with a complete list of inmate releases on a daily basis.
	Sacramento	Sacramento had bi-directional and real-time data sharing with their managed care plan, Molina. This data sharing relationship was facilitated by weekly operational meetings which were held with all participating staff to review processes, discuss status of members, and provide updates regarding Molina's referrals into WPC.
	Alameda	In May 2018, Alameda launched their HMIS system, with over 40 active, participating agencies. The data was used to produce by-name lists of clients who had been prioritized for supportive housing and to track program outcomes.
Implementation of data sharing agreements and consents	Shasta	Shasta implemented a workflow model that included having the prospective enrollee sign an ROI as part of the initial referral packet. Shasta found that having the ROI signed at the outset allowed for a more coordinated approach to eligibility determination.
	Marin	Marin increased the number of partners included on the Pilot's ROI, and recently succeeded in having Marin General Hospital's Compliance Office join and actively participate in the Pilot. This partnership allowed case managers to coordinate with hospital staff in identifying prospective enrollees while they were still in the hospital and improved the development of discharge plans.

Solution	WPC Pilot	Selected Examples
	San Joaquin	San Joaquin found success in obtaining consents through face-to-face engagement. This process facilitated trust and rapport building between the enrollee and care team, while providing an opportunity for the care team to explain the benefits of signed consent.
Completing state reporting requirements related to enrollment, service utilization and/or metrics	Ventura	Due to successful data sharing with their Medi-Cal managed care plan and behavioral health department, Ventura was able to successfully calculate outcome metrics. Ventura noted this was critical because only 40% of ED and inpatient utilization took place within Pilot-affiliated hospitals, where the Pilot could access information through their Cerner EHR.
	Orange	Orange successfully engaged all providers to submit enrollment data on a regular basis to the Pilot team. Although the process was manual, they set clear targets for an electronic coordinated system to come online.
	Riverside	Riverside acquired SAS in order to reduce the amount of time and effort needed to compile reports to DHCS from multiple partner sites and EHRs.
Using data informed decision making to support implementation processes or quality improvement efforts	Los Angeles	Los Angeles published a monthly enrollment dashboard distributed to all program teams and Pilot stakeholders. This dashboard showed several data elements such as monthly enrollments, newly enrolled that month, and cumulatively enrolled to date. Additionally, Los Angeles developed a short weekly dashboard that showed caseload and care plan completion by a community health worker or medical case worker.
	San Francisco	San Francisco integrated the California multiple encounter dataset into their coordinated care management system in order to determine in real-time if a prospective enrollee was on Medi-Cal or not. This also allowed staff to ascertain which of their enrollees' Medi-Cal enrollment was about to expire or who should be assessed for eligibility.
	Ventura	Ventura enabled real-time alerts for ED and hospital events to aid in timely follow-up with WPC enrollees.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, and Program Year 3 Mid-Year Narrative Reports (n=93).
Notes: DHCS is California Department of Health Care Services. ED is emergency department. EHR is electronic health record. HMIS is homeless management information system. ROI is release of information. SAS is statistical analysis system.

Chapter 6: Identification, Enrollment, and Engagement of Eligible Medi-Cal Beneficiaries

WPC Pilots were required to identify eligible Medi-Cal beneficiaries using their pre-defined inclusion criteria, enroll them in WPC, and engage enrollees in care. This chapter reports on strategies used by Pilots to identify, enroll, and engage eligible Medi-Cal beneficiaries in WPC, as well as the following evaluation question: "what key factors aided or hindered the success of specific strategies in implementing or achieving the intended outcomes, and what measures are WPC Pilots taking to address these barriers?" In addition, this chapter reports on the resulting enrollment patterns for the overall program and by target population.

Data sources for this chapter include interim WPC Pilot surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots. Data from Pilots and the 25 narrative reports submitted to DHCS were also included in the following analyses. The data source for enrollment size and pattern analyses were *WPC Enrollment and Utilization Reports* from PY 2 to PY 3. For additional detail on data sources and methodology please see the Analytic Methods and Appendices C, D, and E.

Identifying Prospective Enrollees

In follow-up interviews, WPC Pilots reported using a wide range of strategies to identify eligible Medi-Cal beneficiaries, including use of administrative and electronic medical record data; referrals from partner organizations; warm hand-offs from health and social service partners; and street outreach. Some Pilots, such as Kings, Santa Cruz, and Sonoma, allowed potential clients to self-refer themselves into the program.

> *"So we're trying to figure out ways to identify people when they are in hospitals, or a skilled nursing facility, or someplace where a team can actually go engage them as a captive audience member. Systems need to be built to capture that information in real time and get it out, which we're working on."*
>
> *-Alameda*

Most counties noted that referrals into the WPC program came from diverse sources which included managed care plans, hospitals, clinics, social workers, and law enforcement. Pilots emphasized continuous efforts to build and maintain relationships with participating entities (e.g., hospitals, emergency departments) in order to continue receiving direct referrals and communication about prospective enrollees.

Exhibit 49 highlights specific approaches by Pilots to identify prospective enrollees within their selected target population. These examples demonstrate the variety of strategies used across WPC Pilots.

Exhibit 49: Selected Examples of WPC Pilot Approaches to Identifying Prospective Enrollees

Identification Elements	WPC Pilot	Selected Examples
Use of administrative and electronic medical record data	Contra Costa	Contra Costa employed a predictive risk model to identify prospective enrollees. The model factored in utilization of services, health records, behavioral health issues, and social factors to generate a list of the top 23,000 adults expected to have an avoidable emergency department visit or hospitalization. The higher risk individuals were prioritized for WPC enrollment.
	San Bernardino	San Bernardino employed a scoring mechanism based off data from the health system, public health, and Medi-Cal managed care plans which ranks prospective enrollees based on utilization of emergency department, inpatient hospital stays, and urgent care visits. The scoring list is updated every 12 months.
Referrals	Marin	Marin relied on their partnership with FQHCs to receive referrals and real-time data on prospective enrollees.
	Mariposa (SCWPCC)	Mariposa received referrals from a number of local service providers including the Medi-Cal managed care plans, the Probation Department, and the local public hospital district.
	Napa	Napa's identification process was primarily based on referrals from numerous entry points, including the county's Emergency Medical Services, Police, and Fire Department.
Warm hand-offs	Sacramento	Sacramento attempted to respond to referrals from emergency department visits within two hours and to respond to referrals of hospital inpatients within 24 hours, which allowed them to identify and engage prospective enrollees while they were still in systems of care and to receive a warm handoff from the provider or care team to WPC frontline staff.
Street outreach	Santa Clara	Santa Clara partnered with the Valley Homeless Healthcare Program, which used mobile vans to conduct regular visits to areas with relatively high concentrations of homeless individuals. This increased WPC enrollment through in-field outreach.
	San Francisco	Street medicine and shelter health worked to identify clients for the program in places where homeless individuals typically frequent and congregate.
Self-referrals	Kings	Due to law enforcement's strong working relationship with the WPC program, Kings received many self-referrals from justice-involved individuals due to word of mouth.
	Los Angeles	To identify prospective enrollees for their SUD programs, Los Angeles utilized their substance abuse services help hotline. At the end of the call, a high level overview of WPC was provided and callers were asked whether they were interested in WPC. If the caller expressed interest, the

Identification Elements	WPC Pilot	Selected Examples
		prospective enrollee was assigned to a community health worker for subsequent follow-up.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

Enrollee Engagement and Retention

Many WPC Pilots structured their program to have an intensive outreach and engagement component, to be followed by enrollment into WPC. After enrollment into WPC, care coordination staff employed similar engagement techniques to ensure enrollee retention in the program.

In follow-up interviews, WPC Pilots reported performing a variety of activities to engage beneficiaries in the WPC program, including in-person one-on-one meetings, phone calls, text conversations, street outreach, and/or home visits. Sustained engagement was an important focus of Pilots due to the nature of WPC's vulnerable and often transient target populations. Pilots reported challenges in maintaining engagement, including lack of regular communication with enrollees due to inaccurate or outdated contact information and lack of cell phones, particularly amongst the homeless and the justice-involved target population. As a result, it was important for Pilots to engage enrollees in a variety of locations and through different modalities.

> *"I think the key word there is trust. They build these trusting relationships with the navigators that they don't have. Many of them don't trust the system for whatever reason. They may have had a bad experience or some of them won't come in. They just won't come in to a brick and mortar facility and we have to deal with them right then and there where they're at."*
>
> *-San Mateo*

Several Pilots commented on the importance of developing rapport and trust with clients. For example, Placer and San Joaquin addressed immediate needs (e.g., transportation, hygiene) before moving towards a discussion about other needs (e.g., health outcomes). Another key factor for engaging and promoting rapport with clients was having enthusiastic and dedicated care coordinators and ensuring consistent care coordinator assignment.

Exhibit 50 provides selected examples of these specific strategies WPC Pilots employed to promote and maintain engagement of enrollees.

Exhibit 50: Selected Examples of Strategies for Engagement of WPC Enrollees

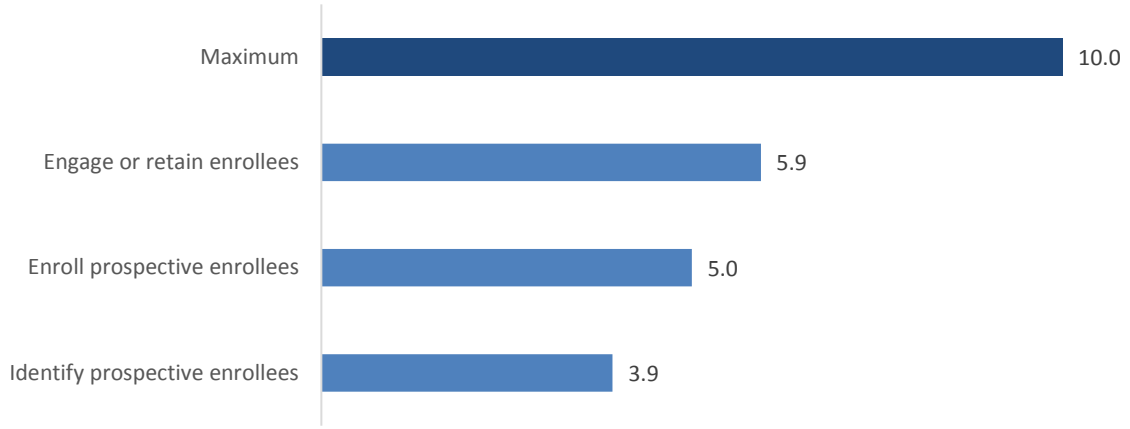
Engagement Elements	WPC Pilot	Selected Examples
Multiple points of contact	Orange	Orange engaged prospective enrollees in various points-of-contact, including the hospital and clinics. The care coordinator also attended appointments or coordinated transportation for their enrollees.
	Riverside	Riverside embedded a nurse in the probation office to keep in constant communication with the probation officer so the care team was able to reach the enrollee, when needed.
Developing trust and rapport	San Bernardino	San Bernardino emphasized they have key traits they identify when hiring their care coordination staff, including kindness, compassion, and respect, in order to foster relationships with their enrollees.
	San Joaquin	San Joaquin highlighted the importance of addressing the immediate needs of prospective enrollees in order to increase trust and rapport.
Consistent care coordinator assignment	Kern	Kern utilized a consistent care coordinator, who was responsible for initial and subsequent engagement. The consistent contact allowed for trust and rapport building throughout the life of the enrollee's participation in WPC.
	Los Angeles	Each enrollee in Los Angeles was assigned to a specific community health worker, which ensured consistency of communication and engagement throughout WPC enrollment. Community health workers maintained contact with enrollees through a variety of mechanisms but primarily by phone (ideally once a week).

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

Challenges and Solutions

In interim Pilot surveys, Pilots were asked to rate the level of difficulty associated with identifying and enrolling prospective enrollees, as well as engaging (or retaining) enrollees in WPC. On a scale of 0 (very low) to 10 (very high), Pilots reported low level of difficulty in identifying (3.9 of 10) eligible enrollees, but found enrolling (5.0) and engaging or retaining enrollees (5.9) to be more difficult (Exhibit 51).

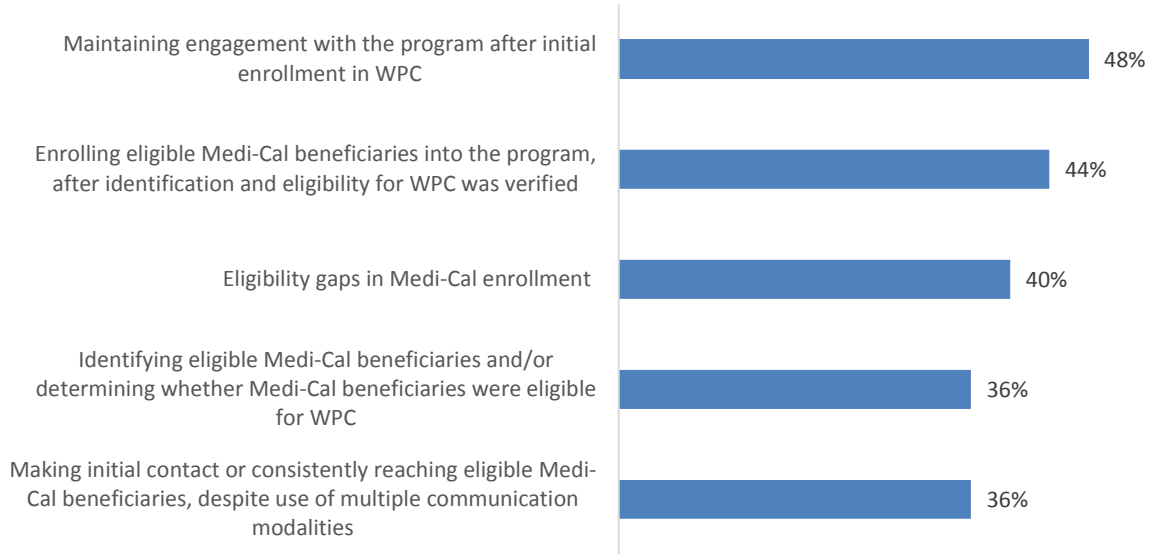
Exhibit 51: Average Rating by WPC Pilots on Difficulty in Identification, Enrollment, and Engagement



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.
Note: WPC Pilots' response to question: "On a scale from 0 to 10 where 0=not difficult and 10=extremely difficult, please indicate how difficult it has been to identify eligible beneficiaries, enroll eligible beneficiaries, and/or engage or retain eligible beneficiaries in WPC program(s)?"

In their narrative reports, Pilots described their challenges and five themes most frequently emerged (Exhibit 52). Nearly half of WPC Pilots (12 of 25) reported challenges related to maintaining engagement with the program after initial enrollment in WPC. Enrollees may not have readily engaged with the program due to a diverse array of enrollee-specific behaviors and beliefs that could be challenging to overcome. For example, WPC Pilots reported challenges in building trust and rapport with enrollees; addressing enrollee misperceptions about the services provided through the WPC Pilot Program (e.g., belief that the program would provide the enrollee secure housing); and a lack of enrollee readiness to work towards their goals and change their lives (i.e., low self-efficacy and/or activation).

Exhibit 52: Most Commonly Identified Challenges in Identifying, Enrolling, and Engaging Prospective Enrollees among WPC Pilots, January 2017-December 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the four reports (n=93).

Over two-fifths of WPC Pilots (11 of 25) reported difficulty enrolling eligible Medi-Cal beneficiaries into the program, after identification and eligibility for WPC was verified. Despite multiple contacts and engagements, eligible Medi-Cal beneficiaries may have declined services or chose to enroll in other similar care coordination or case management programs instead. In early narrative reports, several WPC Pilots noted challenges reaching their initial projected enrollment targets, which were often a result of other implementation challenges (e.g., staffing shortages, unclear referral pathways, and lack of initial partner buy-in).

Two-fifths of WPC Pilots (10 of 25) reported difficulties managing gaps in Medi-Cal eligibility. Medi-Cal enrollment was required for enrollment in WPC; therefore, any lapse in Medi-Cal coverage resulted in a lapse of WPC enrollment. Medi-Cal "churn" was a problem amongst both prospective and current WPC enrollees. Oftentimes, Medi-Cal beneficiaries were unaware of their lapse in Medi-Cal coverage or needed assistance with their renewal applications. Pilots cited efforts to work with appropriate agencies to determine Medi-Cal redetermination dates early to prevent unnecessary breaks in WPC enrollment.

Over one-third of WPC Pilots (9 of 25) reported challenges identifying eligible Medi-Cal beneficiaries and/or determining whether Medi-Cal beneficiaries were eligible for WPC. For example, WPC Pilots cited delays in timeliness and availability of eligibility data (e.g., delay in

claims from managed care plans to calculate ED and inpatient utilization). Additionally, some WPC Pilots identified prospective enrollees who were strong candidates anecdotally and could benefit from WPC, but the Pilot did not have data to support the enrollment decision.

A sizeable number of WPC Pilots (9 of 25) reported challenges with initial outreach and regular communication with prospective enrollees due to inaccurate or outdated contact information (e.g., phone number, address). This was particularly a challenge amongst the homeless (i.e., no permanent address, transient nature, lost phone) and justice-involved target populations (i.e., unpredictability around timing of release and difficulty contacting/locating after release from jail).

Overall, these challenges declined in frequency in PY 3 annual narrative reports.

Specific examples of challenges related to each main category in Exhibit 52 are described in Exhibit 53.

Exhibit 53: Selected Examples of WPC Pilot Challenges in Identifying, Enrolling, and Engaging Prospective Enrollees, January 2017-December 2018

Challenge	WPC Pilot	Selected Examples
Maintaining engagement with the program after initial enrollment in WPC	Kern	Enrollees in Kern demonstrated a lack of engagement when their assigned care coordinator was not available; often, enrollees did not feel comfortable working with another member of the care coordination team and were unwilling to share their concerns with care coordinators they did not have an established connection with.
	Kings	Enrollees in Kings showed a reluctance to re-engage with service providers they had negative experiences with in the past. As a rural county, the Pilot has limited options for certain service and specialty providers.
	Orange	Orange noted difficulties in tracking homeless enrollees after they left a facility, transferred between facilities, or returned to the streets. Due to their transient nature, Orange was not always aware of an enrollee's location in order to continue engagement.
Enrolling eligible Medi-Cal beneficiaries into the program, after identification and eligibility for WPC was verified	San Francisco	San Francisco faced challenges enrolling homeless individuals in WPC as many were Medi-Cal eligible but had not enrolled in Medi-Cal because they perceived the process as burdensome and complicated. Due to their resistance to enroll in Medi-Cal, San Francisco ultimately could not enroll these individuals into WPC.
	Solano	Solano emphasized challenges in enrollment as many prospective enrollees declined services after multiple attempts of outreach and engagement. Solano primarily targeted high utilizers and individuals with SMI and SUD.

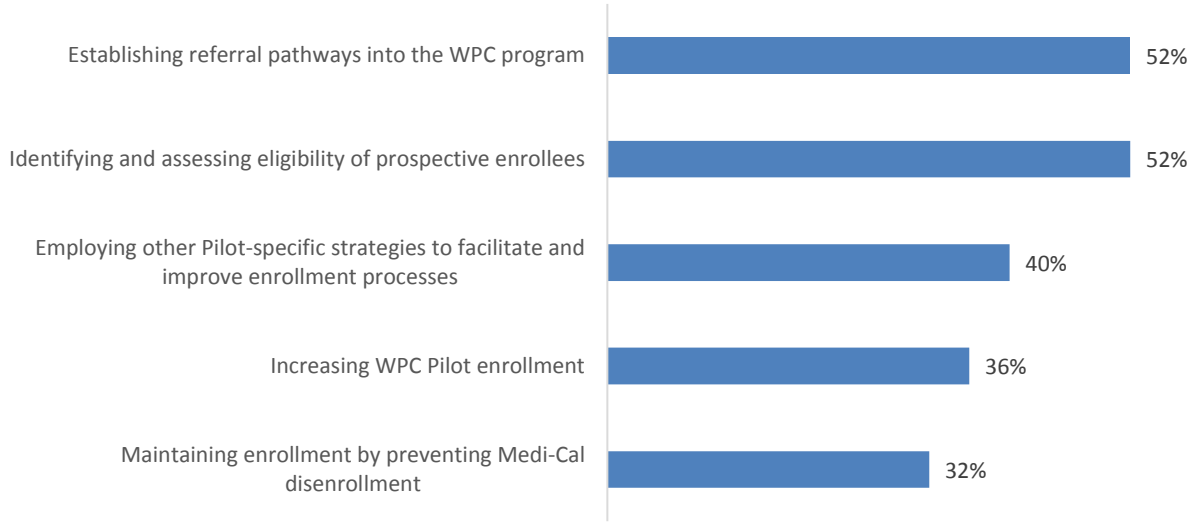
Challenge	WPC Pilot	Selected Examples
Eligibility gaps in Medi-Cal enrollment	Alameda	Alameda noted Medi-Cal "churn" was exacerbated by targeting eligible Medi-Cal beneficiaries who frequently entered and exited incarceration and moved across county lines. This made it difficult to keep track of redetermination dates and to reach out to provide assistance with submitting Medi-Cal renewal paperwork.
	Contra Costa	Contra Costa emphasized that roughly 10-20% of their Medi-Cal population experienced Medi-Cal "churn" each month, which was further complicated by the fact that many enrollees were unaware of the lapse in their Medi-Cal coverage.
	San Diego	San Diego mentioned that service providers didn't have direct access to information on Medi-Cal eligibility. San Diego addressed this through regular data validation by partnering with their Office of Business Intelligence (OBI) and their Office of Eligibility Operations (EO).
Identifying eligible Medi-Cal beneficiaries and/or determining whether Medi-Cal beneficiaries were eligible for WPC	Marin	Marin expressed challenges with accessing reliable data sources to confirm prospective enrollees' eligibility. Marin noted they often anecdotally knew that a prospective enrollee may use multiple systems, but did not have access to those systems' data to support the enrollment decision (e.g., to determine if a prospective enrollee had three or more ED visits or inpatient stays).
	Los Angeles	Los Angeles noted that many individuals in their target population did not know their social security number or date of birth. This prevented frontline staff from being able to quickly verify Medi-Cal status. Although the prospective enrollee appeared to meet WPC eligibility criteria, this delayed the program's ability to move forward seamlessly with enrollment.
Making initial contact or consistently reaching eligible Medi-Cal beneficiaries, despite use of multiple communication modalities	Riverside	Riverside emphasized challenges reaching enrollees as many did not have a mode of communication (e.g., phone, email). Riverside found that clients required to check-in with probation was the best way to maintain communication.
	San Benito (SCWPCC)	San Benito experienced difficulty engaging the homeless population and often had to locate prospective enrollees directly on the streets for outreach and engagement attempts.
	Sonoma	Sonoma noted that referral agencies did not always provide enough information on referred clients. Attempts to locate clients included searching for information on where clients frequented and phone numbers from family or friends.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.

In their narrative reports, Pilots also described solutions to identifying, enrolling, and engaging and five common themes emerged (Exhibit 54). These solutions were often directly the result of policy and procedure changes that were motivated by the challenges identified in the section above. The majority of WPC Pilots (13 of 25) reported solutions related to the establishment of referral pathways, which were the processes through which WPC enrollees were referred by

providers, partners, and other external sources into the WPC program and connected to services that addressed their needs. WPC Pilots developed critical partnerships and specific protocols to facilitate referrals into the program. Commonly identified solutions in this area included: increased community awareness of WPC; formalized contracts with community partners; and creation of formal guidelines and protocols for referring agencies that outlined WPC Pilot goals and enrollment criteria.

Exhibit 54: Most Commonly Identified Solutions in Identifying, Enrolling, and Engaging Prospective Enrollees among WPC Pilots, January 2017-December 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the three reports (n=93).

Thirteen WPC Pilots (52%) reported solutions related to the establishment of referral pathways, which were the processes through which WPC enrollees were referred by providers, partners, and other external sources into the WPC program and connected to services that addressed their needs. WPC Pilots developed critical partnerships and specific protocols to facilitate referrals into the program. Commonly identified solutions in this area included: increased community awareness of WPC; formalized contracts with community partners; and creation of formal guidelines and protocols for referring agencies that outlined WPC Pilot goals and enrollment criteria.

The majority of WPC Pilots (13 of 25) also reported solutions related to the identification and eligibility assessment of eligible Medi-Cal beneficiaries, which allowed WPC Pilots to better understand their Pilot's target population. Examples of solutions in this area included expansion of target populations to increase the number of prospective enrollees; improved strategies for

rapidly identifying and assessing prospective enrollees (i.e., inclusion of client contact information in eligibility data, ability to share target population lists across partners); and use of in-person meetings with partners to identify and strategize around high-need prospective enrollees.

Two-fifths of WPC Pilots (10 of 25) employed other Pilot-specific strategies to facilitate and improve the enrollment process for both frontline staff and eligible Medi-Cal beneficiaries. Examples included expanding responsibilities of street outreach teams to enroll eligible Medi-Cal beneficiaries into WPC and developing electronic forms within the Pilot's care management software to guide care coordinators through necessary steps to ensure efficiency in enrollment.

Over one-third of WPC Pilots (9 of 25) reported solutions in increasing WPC Pilot enrollment, which largely related to Pilots meeting or coming close to their projected enrollment numbers. Improvements in enrollment were a result of many implementation factors including increased staff support, established referral pathways, and familiarity with the program.

Nearly one-third of WPC Pilots (8 of 25) reported solutions in maintaining enrollment by preventing Medi-Cal disenrollment. For example, WPC Pilots established relationships with human services agencies to better understand enrollees' Medi-Cal coverage lapses through improved data sharing, which allowed WPC Pilots to proactively outreach to enrollees for Medi-Cal reinstatement.

Specific examples of solutions related to each main category in Exhibit 54 are described in Exhibit 55.

Exhibit 55: Selected Examples of WPC Pilot Solutions to Identifying, Enrolling, and Engaging Prospective Enrollees, January 2017-December 2018

Solution	WPC Pilot	Selected Examples
Establishing referral pathways into the WPC program	Alameda	Alameda executed formal contracts with partners, which provided improvements to referrals and linkages to other service providers.
	Kings	Kings expedited the referral process for enrollees referred by probation officers. Continued participation was more likely when enrollees were assisted by probation officers to enroll and achieve their goals. Kings also mentioned that probation officers who participated in care plan meetings were more likely to direct enrollees to the Pilot for assistance.
	Napa	Napa developed a "care coordination collaborative" to create and strengthen referral pathways with housing, health, and other community partners. A key process in the collaborative was to dissect case studies of shared

Solution	WPC Pilot	Selected Examples
		enrollees to strategize how to best provide wrap-around services.
Identifying and assessing eligibility of prospective enrollees	San Bernardino	San Bernardino obtained prospective enrollee data from a number of WPC partners, including behavioral health and public health departments, and managed care plans, and made these data available to Pilot staff to access reliable information for outreach and engagement activities.
	Santa Cruz	Santa Cruz participated in meetings with two local safety-net hospitals to identify and better understand high utilizers of ED and inpatient services. These meetings facilitated Santa Cruz's ability to identify and assess eligibility of prospective enrollees on the spot, through in-depth discussions.
	Solano	Solano received referrals from various sources, including: a high-utilizer list from Solano's Medi-Cal Managed Care plan, hospitals, and clinic providers/partners. This provided Solano a continuous source of potential clients and helped to strengthen partnerships. Solano also mentioned they'd consider exploring broadening their referral sources to individuals recently released from incarceration.
Employing other Pilot-specific strategies to facilitate and improve enrollment processes	Riverside	Riverside placed nurses in probation offices to screen for prospective enrollees; these nurses also helped facilitate warm hand-offs and direct referrals of prospective enrollees recently released from incarceration to Pilot staff.
	San Diego	Due to San Diego's late start at enrollment in the Pilot, San Diego consciously engaged partners in an "early enrollment and identification process," which engaged prospective enrollees prior to official WPC implementation. This intentional process strengthened the Pilot's relationship with future partners and improved understanding and enhanced communication about Pilot services to support future enrollees.
	San Joaquin	San Joaquin found success in obtaining signed consents from enrollees after face-to-face interactions. San Joaquin credited their staff for building rapport and trust with enrollees by explaining the benefits of a signed consent. This allowed San Joaquin to share information and better appropriate services for enrollees.
Increasing WPC Pilot enrollment	Placer	Placer was successful in surpassing their enrollment goals for the time period through June 2018 to make progress towards their projected enrollment.
	San Mateo	San Mateo reported satisfaction with their enrollment numbers and their ability to provide a number of services to enrollees including behavioral health, medical services, housing assessments, and transportation.

Solution	WPC Pilot	Selected Examples
Maintaining enrollment by preventing Medi-Cal disenrollment	Contra Costa	Contra Costa worked with a local partner, the Employment and Human Services Division of Contra Costa County, to access Medi-Cal eligibility information to better understand enrollee lapses in Medi-Cal coverage and reduce enrollee loss from the Pilot program due to these lapses.
	Kern	Kern worked with the Kern County Department of Human Services (DHS) to improve how Medi-Cal eligibility and aid codes were reported to the Pilot. Kern also worked with a DHS Medi-Cal Inmate Eligibility Program (MCIEP) assigned worker to better track and assist individuals transitioning from incarceration to release, and reduce Medi-Cal churn.
	San Bernardino	San Bernardino was able to utilize an electronic feed from the County's Transitional Assistance Department to increase efficiency in determining and maintaining Medi-Cal eligibility of WPC enrollees.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.

WPC Enrollment Size and Patterns

Enrollment into WPC began during program year 2 (PY 2, 2017), with enrollment beginning in or after January 2017 for Pilots implementing in January 2017 and in or after July 2017 for Pilots implementing in July 2017. WPC Pilots submitted *WPC Enrollment and Utilization Reports* to DHCS each quarter, beginning in PY 2. These reports contained monthly records for each individual that participated in WPC. Data included enrollment status, enrollment date, disenrollment date, disenrollment reason, target population(s), homeless status, and service utilization. UCLA combined data from all WPC Pilot reports, and used this data for analyses of enrollment size and patterns. UCLA defined enrollment in WPC as any individual that a WPC Pilot reported as enrolled and had an enrollment start date. The *WPC Enrollment and Utilization Reports* also included individuals that were allowed a limited set of services prior to enrollment from WPC Pilots (e.g., outreach/engagement and stays in a sobering center), but ultimately did not enroll into a WPC Pilot. These individuals were not included in the analysis, as they were not enrollees.

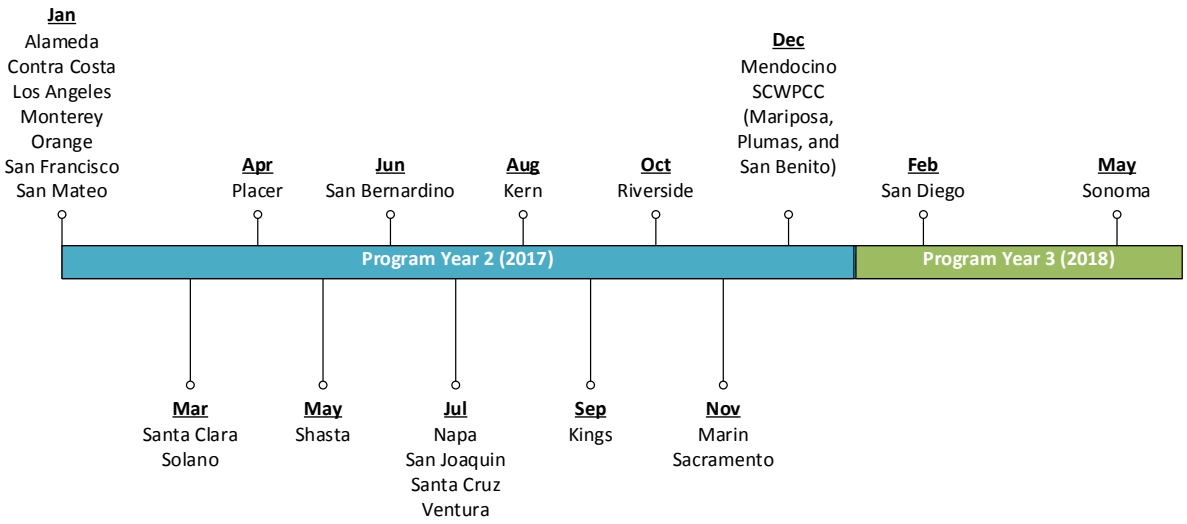
WPC Pilots were not aware if other WPC Pilots had enrolled individuals. Given the transient nature of the many of the WPC target populations, it was likely that individuals would move from one county to another, resulting in a small amount of cross-enrollment. There were 156 individuals that were enrolled at more than one WPC Pilot at the same time and excluded from these analyses. Cross enrollment does not necessarily mean that enrollees received duplicative

services. Another 246 individuals enrolled at more than one WPC Pilots, but their enrollment periods did not overlap and therefore these individuals were included in the analysis. As a result, while there were 108,667 unique enrollees in WPC during PY 2 and PY 3, there were 108,913 unique first enrollments into a WPC Pilot. When analyzing enrollments, each first enrollment at a WPC Pilot was included. Whenever the count of enrollees in an analysis was ten or less, UCLA did not report these numbers in order to protect enrollee privacy.

Enrollment Size

Enrollment in WPC began during PY 2 (2017) for nearly all Pilots. Of the 25 WPC Pilots, seven began enrolling in January 2017 (Exhibit 56). By the end of 2017, 16 more Pilots began enrolling. Two Pilots, San Diego and Sonoma, started enrollment during PY 3 (2018). San Diego needed additional time to establish administrative and delivery infrastructure prior to enrolling and Sonoma delayed their enrollment due to significant wildfires in their community around the time of implementation. The Small County Whole Person Care Collaborative (SCWPCC) was formed among three counties, Mariposa, Plumas and San Benito, and started enrollment in December 2017. In September 2018, Plumas County dropped out of the SCWPCC.

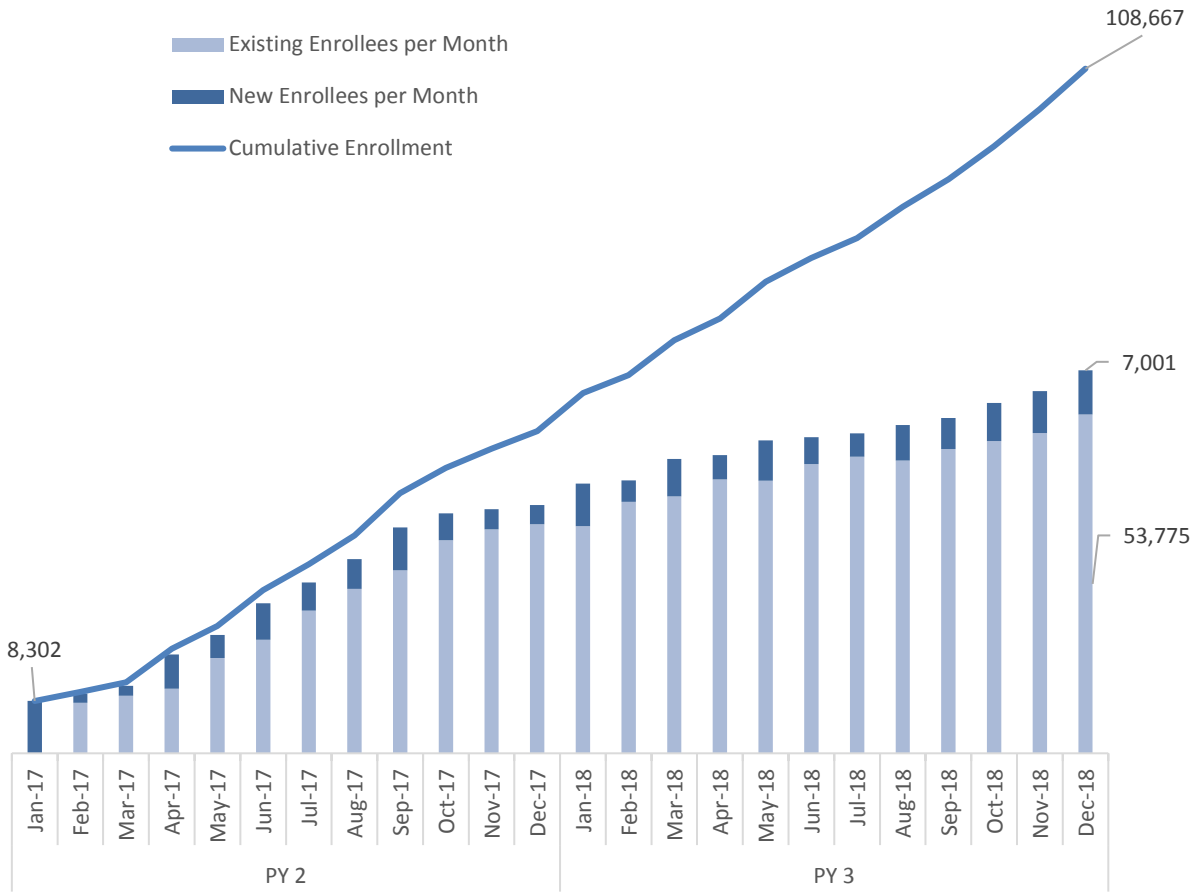
Exhibit 56: Month WPC Pilots Started Enrollment



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Note: Enrollment start was the first month that each WPC Pilot enrolled individuals and provided services. SCWPCC is the Small County Whole Person Care Collaborative. Plumas County dropped out of SCWPCC in September 2018.

In January 2017, a total of 8,302 individuals enrolled in WPC (Exhibit 57). By December 2018, the cumulative total to have ever enrolled in WPC increased to 108,667, with 60,776 currently enrolled (53,775 existing enrollees and 7,001 newly enrolled in December 2018). Monthly new enrollment in the program ranged from 1,430 in February 2017 to 8,302 in January 2017. The average new enrollment per month was 4,883 (data not shown). Enrollment size by Pilot can be found in Appendix R.

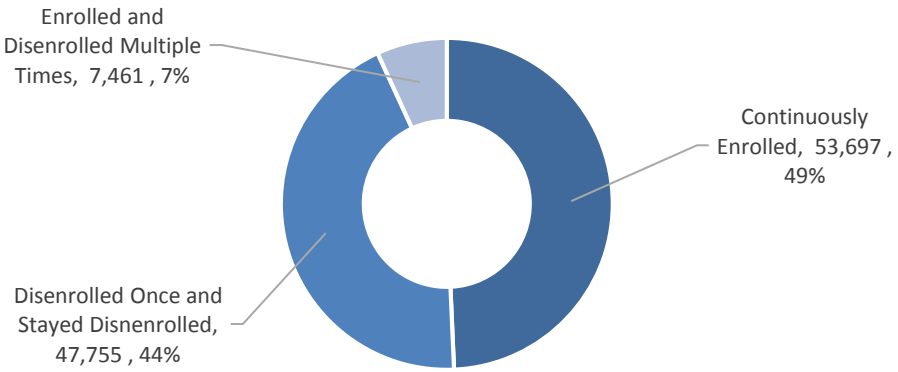
Exhibit 57: Unduplicated Monthly and Cumulative Total WPC Enrollment, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,667 unique enrollees. Does not include re-enrollments. Excludes individuals who received outreach or other allowable WPC services but did not enroll.

As of the end of PY 3 (December 2018), 49% of WPC enrollees had stayed continuously enrolled in the program (Exhibit 58). The percent of enrollees that stayed continuously enrolled varied by Pilot, from 23% of Shasta enrollees to 98% of Marin (data not shown). Given that WPC enrollees could reenroll into the program if they met the criteria for enrollment, some enrollees disenrolled and stayed disenrolled (44%) while others enrolled multiple times (7%).

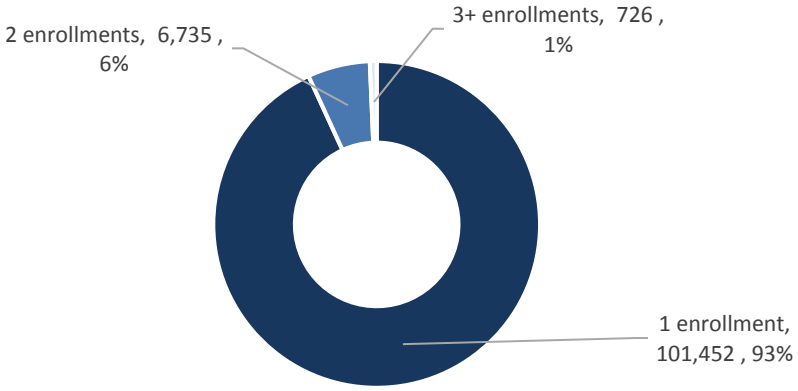
Exhibit 58: Continuous Enrollment and Patterns of Disenrollment in WPC, Overall and by Pilot, December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,913 unique enrollment into a WPC Pilot. Continuously enrolled includes individuals that never disenrolled from a Pilot.

Reenrollment into WPC was allowed when enrollees met enrollment criteria for the program and were interested in returning to the program. Of the 108,913 individuals that enrolled into an unique WPC Pilot, 7% ultimately enrolled in the Pilot more than once (Exhibit 59). A small portion of enrollees (1%) enrolled three or more times.

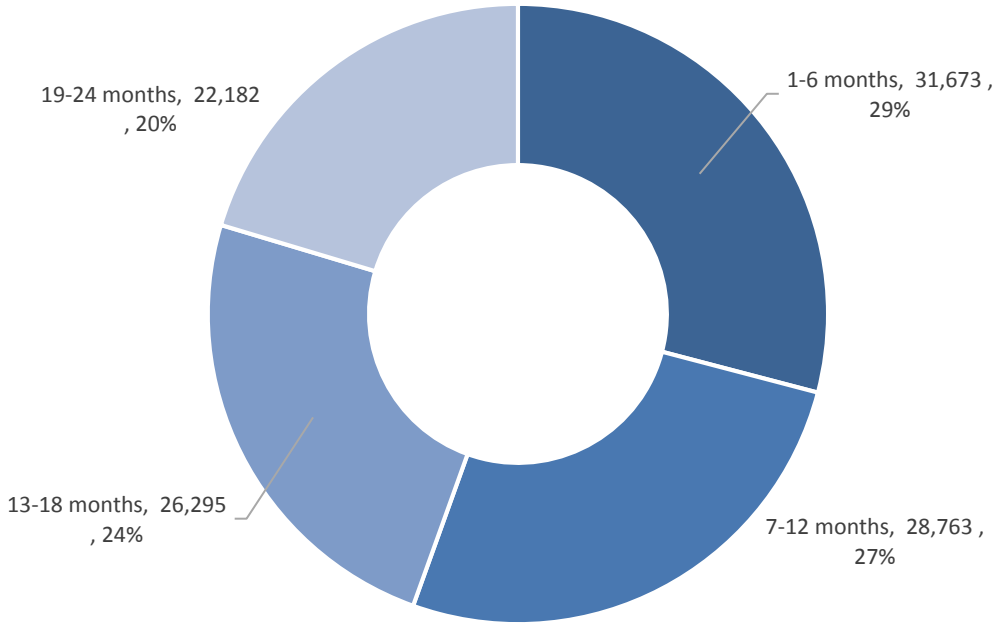
Exhibit 59: Number of Enrollments by WPC Enrollee, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,913 unique enrollment into a WPC Pilot.

Given the staggered enrollment of enrollees into WPC and the different approaches to graduation by Pilot, the length of enrollment at the time of this report by enrollee ranged from 1 to 24 months (data not shown). Exhibit 60 displays the length of enrollment among WPC enrollees through PY 3. Over half of enrollees were enrolled for 12 months of less (56%), while one-fifth were enrolled for 19-24 months. The mean, median and mode length of enrollment in the program was 11.5, 12 and 6 months, respectively (data not shown).

Exhibit 60: Length of Enrollment in WPC, January 2017 to December 2018

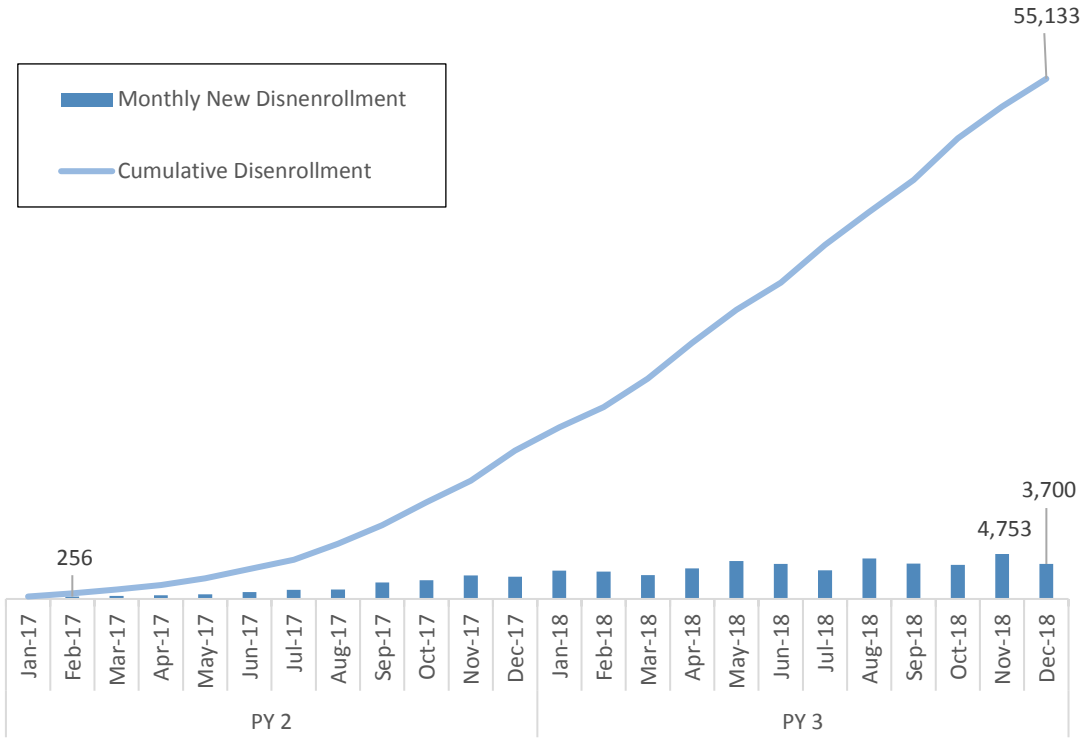


Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,913 unique enrollment into a WPC Pilot.

Disenrollment

Over PY 2 and PY 3, 51% of WPC enrollees disenrolled from the program (data not shown). Disenrollment from WPC began in the second month of the program, February 2017 (Exhibit 61). By the end of PY 3, 55,133 individuals had disenrolled from WPC. The number of new disenrollments per month ranged from 256 in February 2017 to 4,753 in November 2018. The average number of new disenrollments per month was 2,305 (data not shown).

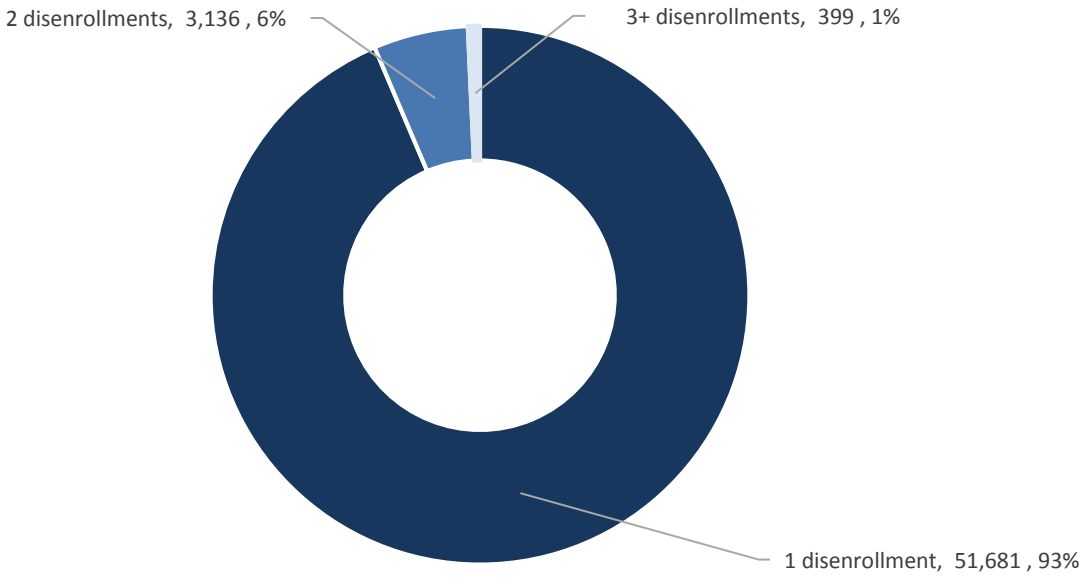
Exhibit 61: Unduplicated Monthly and Cumulative Total Disenrollment in WPC, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 55,133 unique individuals that ever disenrolled from WPC.

Enrollees could re-enroll into WPC after disenrollment, resulting in 3,535 enrollees having more than one disenrollment from the program. Of those that disenrolled from the program multiple times, 6% disenrolled two times and 1% disenrolled three or more times (Exhibit 62).

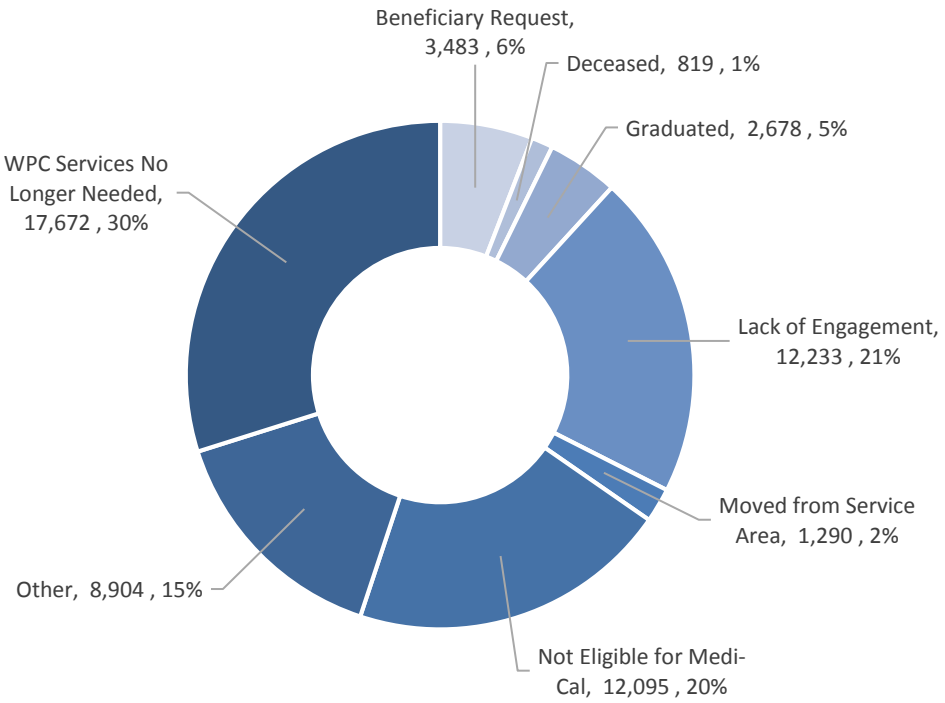
Exhibit 62: Number of Enrollees with One or More Disenrollments from WPC, January 2017 to January 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 55,216 WPC unique individuals by Pilot that disenrolled.

WPC Pilots reported reason for disenrollment in the *WPC Enrollment and Utilization Reports* using a standardized set of disenrollment reasons. An additional reason for disenrollment, "Graduated" was not added until PY 3. Of the 59,174 disenrollments (among 55,216 unique individuals) from WPC during PY 2 and PY 3, the most common reasons for disenrollment were "WPC Services No Longer Needed" (30%), "Lack of Engagement" (21%) and "Not Eligible for Medi-Cal" (20%). Less frequent reasons included "Beneficiary Request" (6%) and "Graduated" (5%, Exhibit 63). Prior to the inclusion of "Graduated," many WPC Pilots reported that they used the "WPC Services No Longer Needed" reason when their enrollees had met their goals and were ready to leave the Pilot. As a result, the "WPC Services No Longer Needed" is a mix of enrollees that were not appropriate or do not benefit from services provided through WPC and those that successfully developed the skills to independently manage their own care.

Exhibit 63: Reason for Disenrollment from WPC, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 59,174 unique disenrollments from WPC with standardized disenrollment reasons among 55,216 individuals. 28 disenrollments were excluded because they did not use standardized disenrollment reasons.

Services without Enrollment

Of the 122,886 individuals identified in *WPC Enrollment and Utilization Reports* to have received services, 14,219 individuals or 11.6% were not ultimately enrolled into WPC by the end of 2018. These individuals ultimately did not enroll in the program either due to lack of engagement or the Pilot determined they did not meet the eligibility criteria. The allowable services received included outreach/engagement and/or short-term stays in sobering centers (specific services provided to these individuals are discussed in Chapter 7: WPC Services Offered and Delivered).

Enrollment Patterns by Target Population

Classification of enrollees into target populations varied by WPC Pilot. Some WPC Pilots classified enrollees into only the target population(s) that was used to initially identify the individual (aligning with the primary target populations of Pilot described in Chapter 4: Structure of WPC Pilots) while others used patient assessment data to classify enrollees into additional target population that were not the primary reason for their enrollment. As a result, while inclusion in a particular target population indicates that an enrollee fits the criteria for that target population, exclusion from a target population does not guarantee that an enrollee does not meet the criteria. For example, Napa's primary target population was the homeless and all enrollees in the Pilot are categorized only as homeless. In contrast, Santa Cruz's primary target populations were those with chronic physical conditions and/or SMI/SUD, yet they used health records and assessments to categorize their enrollees in all six possible target populations. UCLA identified which Pilots reported at least ten enrollees in each target population in Exhibit 64.

Exhibit 64: WPC Pilots Reporting at Least Ten Enrollees by Target Population, January 2017 to December 2018

WPC Pilot	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-Risk-of-Homelessness	Justice-Involved
Alameda	X			X		
Contra Costa	X			X		
Kern	X	X	X	X	X	X
Kings		X	X			X
Los Angeles	X	X	X	X	X	X
Marin	X			X	X	
Mendocino	X	X	X	X	X	X
Monterey	X	X	X	X	X	
Napa				X		
Orange	X	X	X	X	X	
Placer	X	X	X	X	X	X
Riverside	X	X	X	X	X	X
Sacramento	X	X	X	X	X	
San Bernardino	X	X				
San Diego	X	X	X	X	X	X
San Francisco	X		X	X		
San Joaquin	X		X	X	X	X
San Mateo	X		X	X		
Santa Clara	X	X	X	X		
Santa Cruz	X	X	X	X	X	X

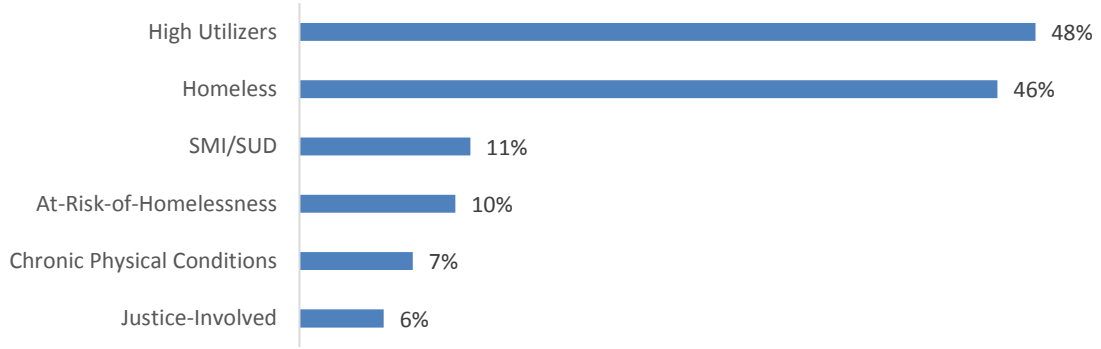
WPC Pilot	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-Risk-of-Homelessness	Justice-Involved
Shasta	X	X	X	X	X	
SCWPCC	X	X	X	X	X	X
Solano	X	X	X	X	X	
Sonoma	X	X	X	X	X	
Ventura	X			X		
Total	**23**	**17**	**19**	**23**	**16**	**10**

Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,667 unique individuals. When count for a target population was less than 11 individuals, it was not included. SMI/SUD is severe mental illness and/or substance use disorder. SCWPCC is the Small County Whole Person Care Collaborative.

Twenty-three WPC Pilots reported enrollees in the high utilizers and homeless target populations. The next most commonly reported target populations were SMI/SUD (19 of 25), chronic physical conditions (17), and at-risk-of-homelessness (16). The least often reported target population was justice-involved, with only ten Pilots.

Of the 108,667 individuals who enrolled in WPC during PY 2 and PY 3, Pilots classified 48% as high utilizers and 46% as homeless (Exhibit 65). The next most common target populations that enrollees were classified as were SMI/SUD (11%) and at-risk-of-homelessness (10%). Enrollees were least often classified as having chronic physical conditions (7%) and justice-involved (6%) by WPC Pilots.

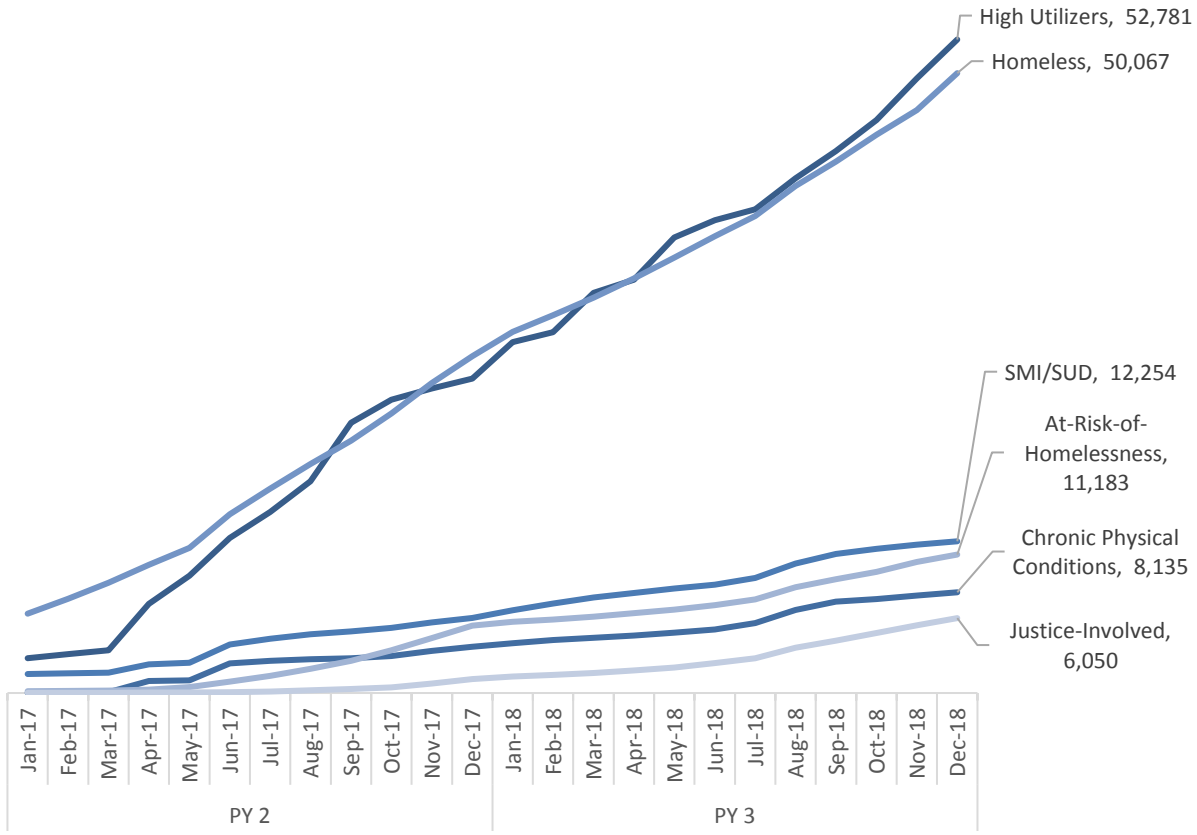
Exhibit 65: WPC Total Enrolled Population Target Population Classifications as of December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,667 unique enrollees. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Over the first two years of WPC enrollment, the growth in cumulative, unduplicated total enrollment was greatest among enrollees classified as high utilizers and homeless (Exhibit 66). The remaining target populations also grew over time, but at a slower pace.

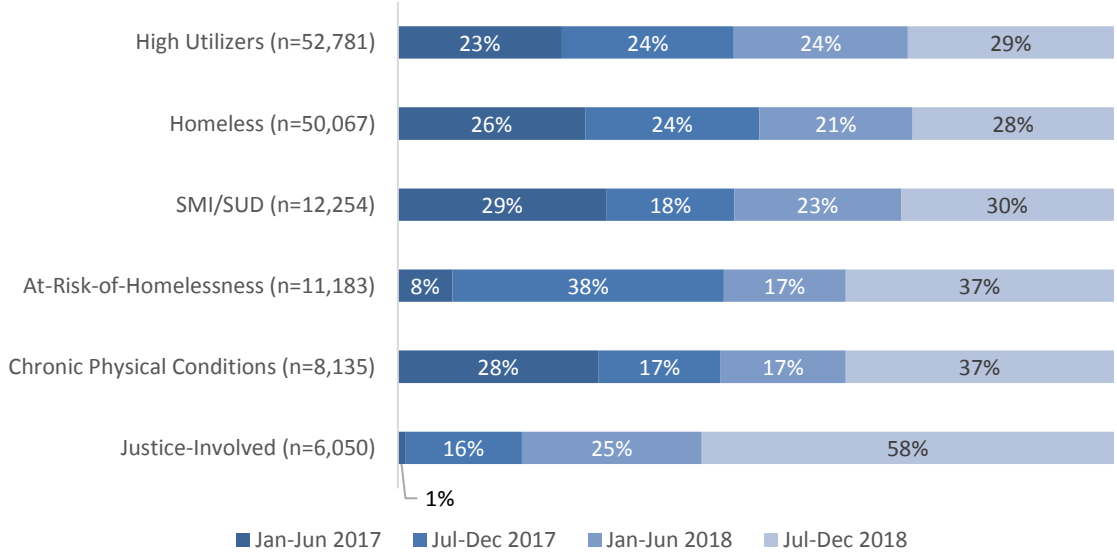
Exhibit 66: Cumulative Total Enrollment in WPC by Target Population, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,667 unique enrollees. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Pilots enrolled different target populations at different times during PY 2 and PY 3 (Exhibit 67). For example, enrollment into high utilizers and homeless target populations was consistent over time but the majority of justice-involved enrollees (58%) were enrolled during the last six months of PY 3.

Exhibit 67: WPC Time of Enrollment by Target Population, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,667 unique enrollees. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Length of enrollment by target population was influenced by the time at which the Pilots reporting on a given target population started enrollment, the graduation protocols for the Pilots reporting on a given target population and the level of need of the individuals in that target population. Ultimately, UCLA found that the homeless and SMI/SUD target populations had the longest average length of enrollment (Exhibit 68). The short length of enrollment of the justice-involved population is likely explained by the fact that the majority of this population enrolled during the second half of PY 3 (Exhibit 67).

Exhibit 68: WPC Length of Enrollment in Months by Target Population, January 2017 to December 2018

	High Utilizers (n=52,781)	Homeless (n=50,067)	SMI/SUD (n=12,254)	At-Risk-of-Homelessness (n=11,183)	Chronic Physical Conditions (n=8,135)	Justice-Involved (n=6,050)
Mean	11.7	12.2	12.1	10.3	11.5	6.7
Median	12	13	12	12	11	5
Mode	16	24	19	5	19	5

Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,667 unique enrollees. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Chapter 7: WPC Services Offered and Delivered

A major goal of WPC was to "increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries." This chapter addresses the following evaluation question: What services did WPC enrollees receive?

Data sources for this chapter used to categorize the services reported by WPC Pilots into eight common service categories include WPC Pilot applications, the 25 narrative reports submitted to DHCS, interim WPC Pilot surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots. The date source for estimated service delivery was quarterly *WPC Enrollment and Utilization Reports* from PY 2 and PY 3. For additional detail on data sources and methodology please see the Analytic Methods and Appendices C, D, and E.

Pilots had the flexibility to provide services that would best fit the needs of their target populations and could be delivered with the existing infrastructure and resources. Services delivered by Pilots could only be identified through an examination of bundled (PMPM or per-member-per-month) or specific services (FFS or fee-for-service) that Pilots used to report to DHCS and receive payment. Bundled services varied in what combinations of services were included and associated costs, as they were tailored by each Pilot to fit the needs of the population they expected to serve. For this analysis, the services provided by the Small County Whole Person Care Collaborative (SCWPCC) Pilot (San Benito, Plumas, and Mariposa) were analyzed separately as each used different bundles of services.

Eight categories of services were identified using this methodology (Exhibit 69). For example, Pilots that described providing assistance in accessing and obtaining sustainable housing solutions or financial assistance used to maintain and achieve healthy living situations in a specific bundle or specific service in any of the above sources of data were considered to provide housing support through that bundle or service. Of the services listed, sobering centers, medical respite, and outreach were infrequently included in bundles and therefore most clearly identified.

Exhibit 69: Descriptions of Service Categories

Service Category	
Outreach	Outreach services to identify prospective enrollees and assess their eligibility in the field or in clinical and other settings.
Care Coordination	Coordination of medical, behavioral health, and social services to improve health and reduce unnecessary utilization in high-risk, high utilizer target populations.
Housing Support	Assistance in accessing and obtaining sustainable housing solutions in order to maximize the number of enrollees living in healthy, stable living

	situations. Financial assistance used to maintain and/or achieve healthy, stable living situations.
Peer Support	WPC staff with lived experience similar to the target populations who provide knowledge, guidance, and emotional, social, or practical support to WPC enrollees. These individuals often provide care coordination and housing support services, as well as guiding and supporting enrollees through behavioral health and social services.
Benefit Support	Assistance with applying for, obtaining, and/or appealing for public benefits (e.g., Social Security Income (SSI), Cal-Fresh, etc.).
Employment Assistance	Workforce training on resume building, interview skills, and/or other supports necessary in order to obtain a job.
Sobering Center	A safe environment for intoxicated individuals to receive detoxification services.
Medical Respite	Post-acute respite services for enrollees discharged from the hospital and other inpatient settings, which allow enrollees to recuperate in a safe environment until they have the resources to care for themselves.

Source: WPC Applications, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.
Note: Service categories were identified from bundled or specific services that Pilots used to report services delivered under WPC to DHCS.

WPC Services Offered

The examination of (1) WPC Pilot applications (n=25); (2) follow-up interviews with leadership and frontline staff (n=27); (3) interim Pilot surveys (n=27); (4) narrative reports submitted to DHCS (n=25); and (5) quarterly *WPC Enrollment and Utilization Reports* showed the capacity for services by each Pilots, ranging from three (San Benito and Shasta) to seven (Kings and Los Angeles, Exhibit 70). Furthermore, that data show frequency of offer of services program-wide, indicating capacity for care coordination and housing support services by all Pilots. The majority of Pilots also offered peer support (74%) and benefit support (67%). Employment assistance was less common, and offered by only five Pilots (19%).

Exhibit 70: Service Categories Offered by WPC Pilots

WPC Pilots	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Number of Services
Alameda		✓	✓	✓			✓		**4**
Contra Costa		✓	✓	✓	✓	✓			**5**
Kern	✓	✓	✓	✓	✓	✓			**6**
Kings	✓	✓	✓	✓	✓	✓	✓		**7**
Los Angeles		✓	✓	✓	✓	✓	✓	✓	**7**
Marin	✓	✓	✓	✓	✓				**5**

WPC Pilots	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Number of Services
Mariposa (SCWPCC)	✓	✓	✓					✓	**4**
Mendocino		✓	✓	✓			✓	✓	**5**
Monterey	✓	✓	✓	✓	✓		✓		**6**
Napa		✓	✓	✓	✓			✓	**5**
Orange		✓	✓	✓				✓	**4**
Placer		✓	✓	✓	✓			✓	**5**
Plumas (SCWPCC)	✓	✓	✓					✓	**4**
Riverside	✓	✓	✓		✓				**4**
Sacramento	✓	✓	✓	✓	✓				**5**
San Benito (SCWPCC)	✓	✓	✓						**3**
San Bernardino	✓	✓	✓		✓				**4**
San Diego	✓	✓	✓	✓	✓				**5**
San Francisco	✓	✓	✓		✓			✓	**5**
San Joaquin		✓	✓	✓				✓	**4**
San Mateo		✓	✓	✓	✓		✓		**5**
Santa Clara		✓	✓	✓			✓	✓	**5**
Santa Cruz	✓	✓	✓	✓	✓				**5**
Shasta		✓	✓	✓					**3**
Solano		✓	✓	✓	✓	✓			**5**
Sonoma	✓	✓	✓	✓	✓				**5**
Ventura	✓	✓	✓		✓			✓	**5**
% Pilots Offering	**56%**	**100%**	**100%**	**74%**	**67%**	**19%**	**26%**	**41%**	

Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and Follow-up Interviews with Lead Entities and Frontline Staff conducted from September 2018-March 2019
Notes: Service categories were identified from bundled or specific services that Pilots used to report services delivered under WPC to DHCS. The three counties in the Small County Whole Person Care Collaborative (SCWPCC) (Mariposa, Plumas and San Benito) were counted separately as they reported unique combinations of services.

WPC Estimated Service Delivery

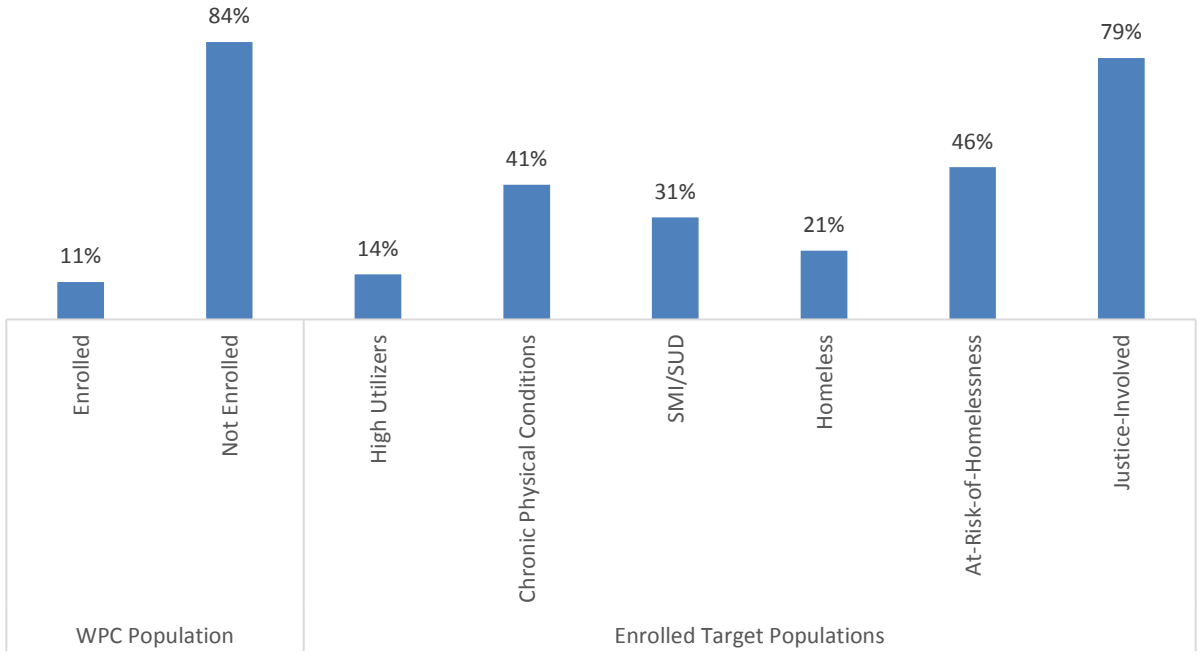
After categorizing the PMPM and FFS categories by services provided, UCLA used enrollees' WPC service utilization as reported in quarterly *WPC Enrollment and Utilization Reports* to identify what proportion of individuals potentially received each of the eight service categories. We specifically examined the rates for eight groups: (1) individuals enrolled in a Pilot, (2) individuals that received services but did not enroll in the Pilot, and (3-8) each of the six target populations. This method of identifying which services each individual received from WPC was

limited by the use of PMPM bundles because the inclusion of a service in a bundle does not guarantee that all individuals in that bundle received that service. Subsequently, the proportion of individuals receiving services may be overestimated, particularly for those service types that Pilots were typically reimbursed through PMPM bundles.

Outreach

Some (56%, Exhibit 70) Pilots offered outreach and engagement services to potential enrollees separately from care coordination service bundles. This service was designed to meet potential enrollees in multiple settings including homeless encampments, streets, clinics, or wherever they may be found. At the time of this report, 11% of the enrolled population and 84% of those that did not ultimately enroll received these services (Exhibit 71). Among the enrolled WPC target populations, 79% of the justice-involved target population received these services, compared to only 14% of the high utilizer population. These outreach services were reimbursed on an FFS basis, rather than as part of a PMPM bundle.

Exhibit 71: Estimated Outreach Service Delivery to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

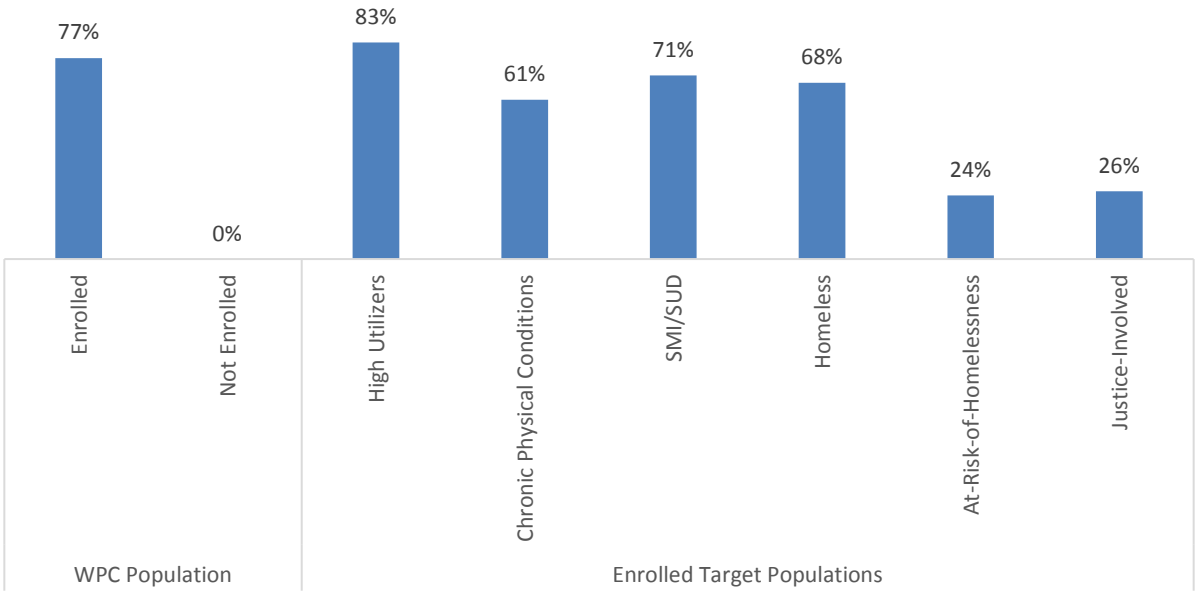
Pilots varied in their outreach and engagement approach. For example, Sacramento used outreach navigators to identify potential enrollees and refer them for WPC eligibility

determination and enrollment, while Monterey provided targeted outreach services in conjunction with other services to help establish trust and rapport with enrollees. More detailed information regarding overall activities of Pilots in the identification, enrollment, and engagement efforts are provided in the Chapter 6: Identification, Enrollment, and Engagement of Eligible Medi-Cal Beneficiaries.

Care Coordination

All Pilots offered care coordination (Exhibit 70). However, an estimated 77% of WPC enrollees received this service (Exhibit 72). This estimate included those newly enrolled who were being assessed prior to receipt of care coordination services as well as a subset of enrollees who were linked to other providers without care coordination. Among the enrolled WPC target populations, high utilizers, those with chronic physical conditions or SMI/SUD, and the homeless had the highest rates of services that included care coordination (61-83%). In comparison, those in the at-risk-of-homelessness and justice-involved target populations had lower rates of estimated care coordination and case management at 24% and 26%, respectively. All WPC Pilots funded care coordination services through PMPM bundles (27 of 27), but some (5) provided additional care coordination services through FFS. More detailed information regarding overall activities of Pilots in care coordination efforts is provided in the Chapter 8: Care Coordination.

Exhibit 72: Estimated Care Coordination Service Delivery to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



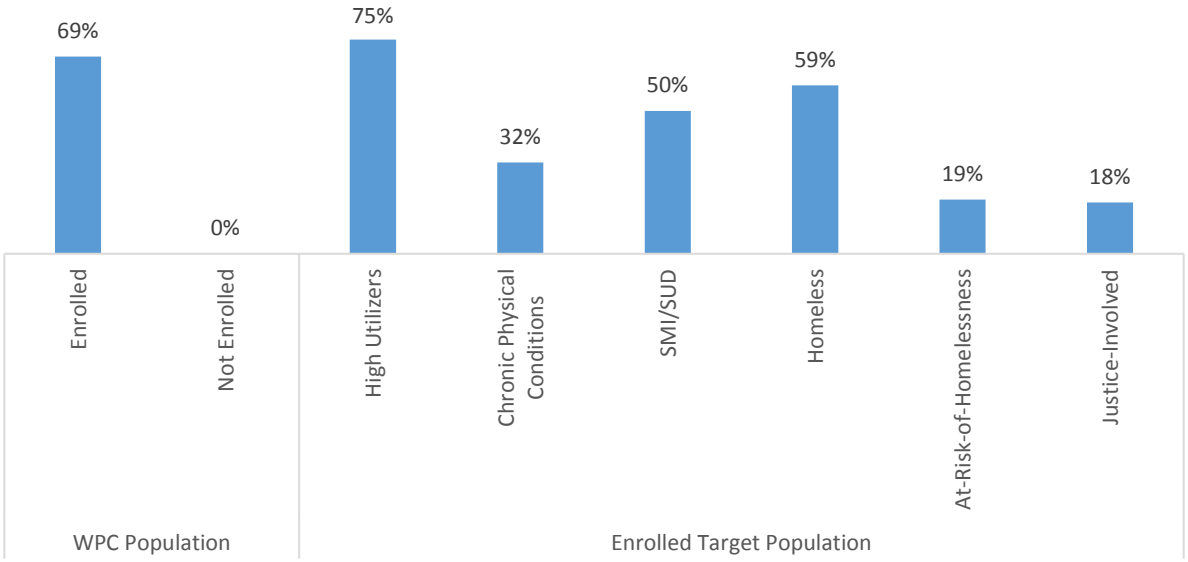
Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.

Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

Housing Support

All Pilots offered housing support services (Exhibit 70). But, an estimated 67% of WPC enrollees received this service (Exhibit 73). Among the enrolled WPC target populations, 75% of high utilizers were offered services that included housing support compared to 59% of the homeless target population. The target populations with the lowest level of housing support availability were the at-risk-of-homelessness (19%) and justice-involved (18%). Almost all Pilots were reimbursed for housing support services via PMPM bundles (26); six of these Pilots also received FFS reimbursement for additional, discrete housing services.

Exhibit 73: Estimated Delivery of Housing Support Service to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

WPC Pilots often used specialized staff (e.g., social workers) to provide these services, which focused on helping enrollees live in the least restrictive community-based setting appropriate to their needs. Staff providing these services typically focused on identifying and mitigating barriers to secure housing placements and facilitating enrollee access to short-term shelters, coordinated entry systems, and housing benefit services. For example, staff might work directly with landlords to mediate disputes, encourage renting to enrollees with negative rental histories, and/or assist landlords in accessing programs that reward them for renting their properties to underserved populations. Pilots also promoted skill-building among their enrollees to make them better tenants and when necessary, facilitated access to legal aid for

resolving housing issues. Housing support services could be quite time-intensive, with Marin estimating an average of 36 hours of face-to-face housing-based case management per enrollee per year.

Individuals who have been offered housing could not always accept or maintain placement due to obstacles such as insufficient funds for first/last month's rent or inability to afford modifications that will make the space suitable for meeting their medical needs. To mitigate these barriers, just over half of Pilots (15 of 27) included housing funds in their housing support services to provide financial assistance with a wide range of housing-related needs: security deposits, set-up fees for utilities or service access, first month utilities, payment of outstanding utility bills, furniture, moving costs, cleaning services prior to move-in, home modifications (e.g., A/C and/or heater), medically necessary services (e.g., hospital beds or lifts), credit repair, criminal record expungement, etc. Selected examples of housing support services by Pilot are provided in Exhibit 74.

Exhibit 74: Selected Examples of Housing Support in WPC

WPC Pilot	Example of Housing Support
Alameda	Alameda's housing transition service bundle included elements essential for enrollees' transition to attaining housing. Funds were used for security deposits, set-up fees for utilities or service access, first month utilities, furniture, moving costs, cleaning services prior to move-in, home modifications (e.g., A/C and/or heater), medically necessary services (e.g., hospital beds or lifts).
Marin	Marin had a housing-based case management component where enrollees who were homeless or precariously housed were supported by a case manager who worked to secure and sustain housing while also promoting awareness and teaching strategies that reduced the likelihood of a return to homelessness in the future.
Napa	Napa provided training on housing rights (e.g., occupancy and eviction issues) for people with disabilities, families with children, and other classes protected in the Fair Housing Act.
Placer	Placer provided a housing services bundle for homeless or individuals at-risk-of homelessness that worked towards obtaining housing and developing daily living skills to remain stable in their new living situation. Services included housing assessments, developing an individualized housing support plan, assistance with the housing application, and identifying and securing available resources to assist with subsidizing rent.
Riverside	Riverside's housing bundle included financial assistance to provide money to landlords for up to a triple security deposit. Landlords were usually skeptical of providing housing to new probationers. Through the deposit, however, landlords were incentivized to provide housing to this population.
San Benito (SCWPCC)	San Benito provided financial assistance for credit repairs and/or criminal record expungement in order to better position enrollees for housing.
Santa Cruz	Santa Cruz enrollees met with WPC staff up to twice daily or weekly to address poor tenancy skills, which affected their ability to maintain stable, housing situations.

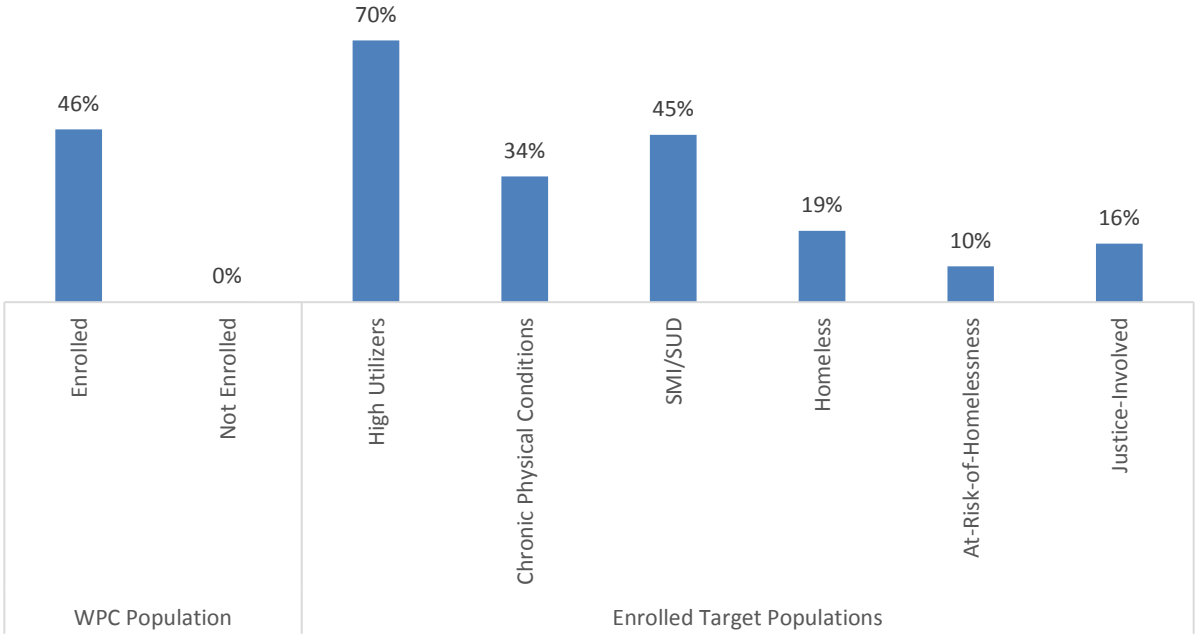
Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and Follow-up Interviews with Lead Entities and Frontline Staff conducted from September 2018-March 2019

Note: SCWPCC is the Small County Whole Person Care Collaborative

Peer Support

Twenty WPC Pilots (74%, Exhibit 70) offered a peer support model where individuals with lived experiences similar to that of their Pilot's enrollees engaged with and advocated for enrollees and provided a range of services, including care coordination, housing support and behavioral health services. Among WPC enrollees, an estimated 46% received a PMPM bundle or FFS intervention that included peer support or a peer providing services (Exhibit 75). Enrollees in the high utilizer and SMI/SUD target populations were the most likely to receive services that offered peer support at 70% and 45%, respectively. In contrast, enrollees in the at-risk-of-homelessness and justice-involved target populations were the least likely to receive services that offered peer support. Most WPC Pilots funded peer support services through PMPM bundles only (17 of 20) rather than as an FFS intervention (2) or a combination of the two (1).

Exhibit 75: Estimated Delivery of Peer Support Service to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

Peers were described as better able to establish trust with WPC enrollees, and therefore critical for improving enrollee engagement with WPC services and/or adherence to care plans. Peer workers were typically embedded as a member of the care coordination team, and targeted a wide range of different vulnerable populations (e.g., individuals experiencing homeless,

substance abuse disorder, justice-involved individuals, etc.). Selected examples of peer support services by Pilot are shown in Exhibit 76.

Exhibit 76: Selected Examples of Peer Support Services in WPC

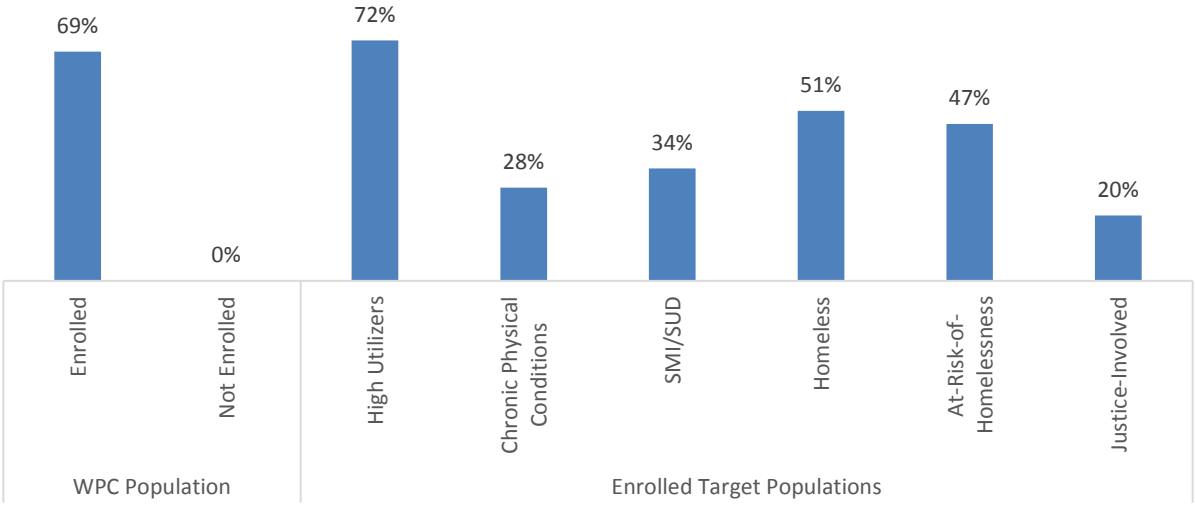
WPC Pilot	Example of Peer Support Services
Mendocino	Mendocino included peer extension workers who provided high intensity trauma-informed support to enrollees.
Placer	Placer relied upon Peer Advocates who were part of the Comprehensive Complex Care Coordination (CCCC) team. Peers were trained with motivational interviewing and their own lived experience with challenges such as chronic health conditions, mental illness, substance use disorders (SUD), homelessness, and legal troubles in order to engage with enrollees in overcoming similar challenges in their lives.
San Mateo	San Mateo utilized a program called Mentors in Discharge, which matched trained peers with psychiatric emergency services (PES) and/or emergency department (ED) experience with patients prior to discharge. As peers, they simultaneously served as mentors, providing ongoing support and engagement to sustain client commitment to recovery.
Shasta	Part of Shasta's housing case management services included volunteer peer support specialists who conducted home visits alongside social workers. During home visits, peer support specialists encouraged enrollees to engage in substance use treatment, mental health resource center wellness programs, and other community programs to promote recovery and maintain housing.

Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and Follow-up Interviews with Lead Entities and Frontline Staff conducted from September 2018-March 2019.

Benefit Support

Eighteen WPC Pilots (67%, Exhibit 70) offered benefit support services to assist enrollees with accessing and maintaining benefits. Among WPC enrollees, an estimated 69% received a PMPM bundle or FFS intervention that included benefit support (Exhibit 77). Among the various target populations, high utilizers and the homeless were most likely to receive services that offered benefit support. Those with chronic physical conditions and the justice-involved were the least likely to receive services that offered benefit support. Most WPC Pilots funded benefit support services through PMPM bundles (14 of 18) rather than an FFS intervention (3) or a combination of PMPM and FFS (1).

Exhibit 77: Estimated Delivery of Benefit Support Service to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



Source*: WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

Benefit support services covered a wide range of services, including assistance with applications for Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Medi-Cal, CalFresh, and/or CalWorks (e.g., either in completing applications, obtaining critical eligibility documents such as certified mail and identification cards, preparing medical summary reports), benefits advocacy (e.g., appealing initially rejected applications), transportation to appointments, and other miscellaneous services. For example, Contra Costa provided enrollees with temporary phones in order to allow the Pilot and benefit agencies to maintain contact with enrollees, while Kern offered childcare services so enrollees could attend needed appointment and services. Selected examples of benefit support services are found in Exhibit 78.

Exhibit 78: Selected Examples of Benefit Support Services in WPC

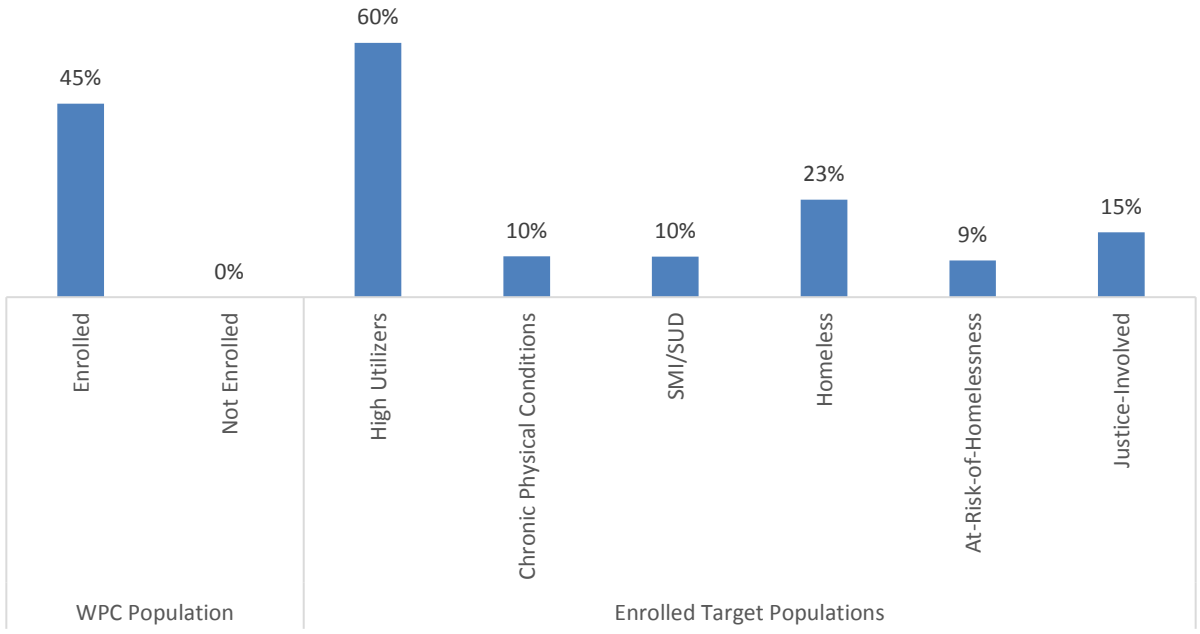
WPC Pilot	Example of Benefit Support Services
Contra Costa	Contra Costa provided temporary phones to enrollees for communication purposes.
Napa	Napa provided transportation vouchers for enrollees in order for them to attend scheduled social, medical, and behavioral health agencies.
Solano	Solano assisted enrollees in obtaining Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Advocacy. This included assistance with obtaining critical eligibility documents (e.g., birth certificates, identification cards, certified mail), preparing detailed Medical Summary Reports, gathering and paying for potential costs for health records, and appealing initially rejected applications.

Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and Follow-up Interviews with Lead Entities and Frontline Staff conducted from September 2018-March 2019.

Employment Assistance

Five WPC Pilots (19%, Exhibit 70) offered employment assistance. Among WPC enrollees, an estimated 45% received a PMPM bundle or FFS intervention that included employment assistance (Exhibit 79). Among the target populations, high utilizers were the most likely to receive services that offered employment assistance (60%). The remaining target populations had a rate between 9% and 23%. Most Pilots funded these services though a PMPM bundle (4 of 5), while one Pilot funded employment assistance services through a combination of PMPM and FFS.

Exhibit 79: Estimated Delivery of Employment Assistance Service to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



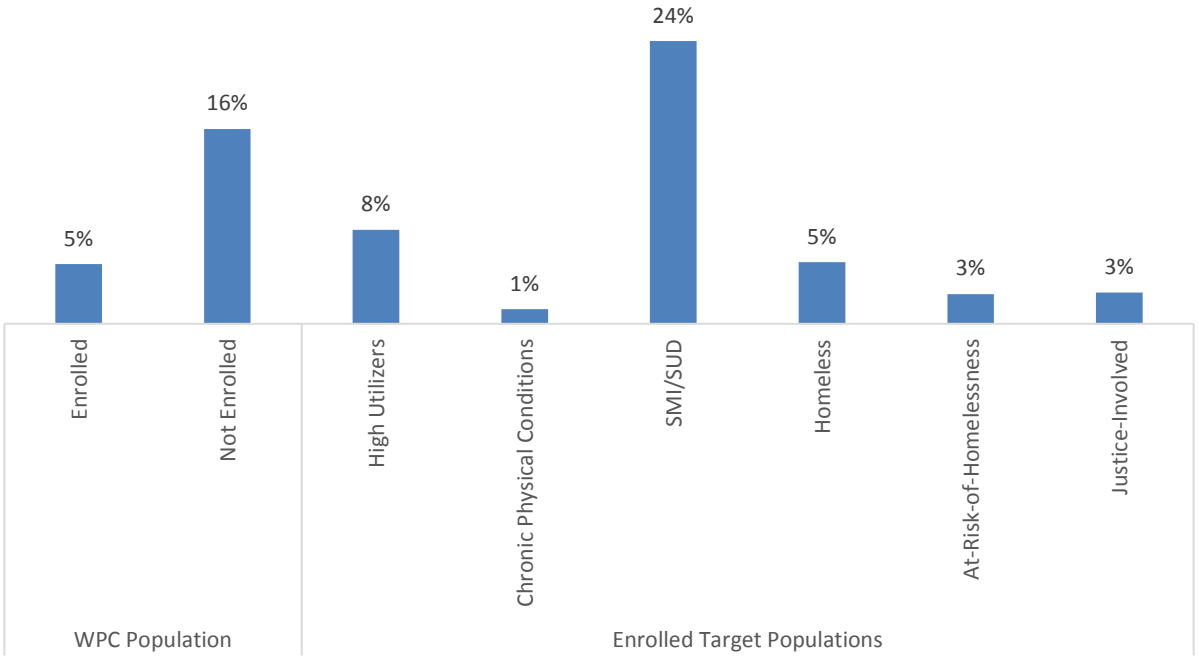
Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

Employment assistance was intended to support enrollees with developing skills and connections that would improve their chances of obtaining employment. For example, Kern provided enrollees with training on personal finance, resume building, interview skills, application assistance, and other supportive services. Kings provided these services as well as body ink removal services in order to increase clients' employability.

Sobering Centers

Seven WPC Pilots provided sobering center services (26%, Exhibit 70) as a safe space to recover from the acute effects of alcohol and drug intoxication and as an alternative to placement in ED, emergency psychiatric services, hospitals, and/or incarceration. The use of WPC sobering centers was not restricted to only WPC enrollees; therefore, both WPC enrollees and potential enrollees used the centers. While 5% of overall WPC enrollees received services that included sobering centers, 16% of individuals that received WPC services without ultimately enrolling at the time of this report, received services that included sobering centers (Exhibit 80). Among the enrollees in the WPC target populations 24% of the SMI/SUD group received services that included sobering center compared to 8% or less of the other target populations. Five Pilots offered hands-on services to transition patients into longer-term care after discharge from the sobering center. Sobering center services were typically funded through FFS interventions (5 of 7) rather than as PMPM bundles (2).

Exhibit 80: Estimated Delivery of Sobering Centers Service to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

Pilots had different criteria for the individuals that used their sobering centers and the services offered within the center. Some Pilots offered specific services to patients with SUD and a co-occurring mental illness, while other Pilots offered more comprehensive, multidisciplinary

services. Most Pilots with sobering centers only permitted individuals to stay for 24 hours or less; Kings, which required patients to stay for a longer period of time (e.g., average of three days) to complete detox, was an exception rather than the norm. Exhibit 81 highlights selected examples of sobering center services in WPC Pilots.

Exhibit 81: Selected Examples of Sobering Center Services in WPC

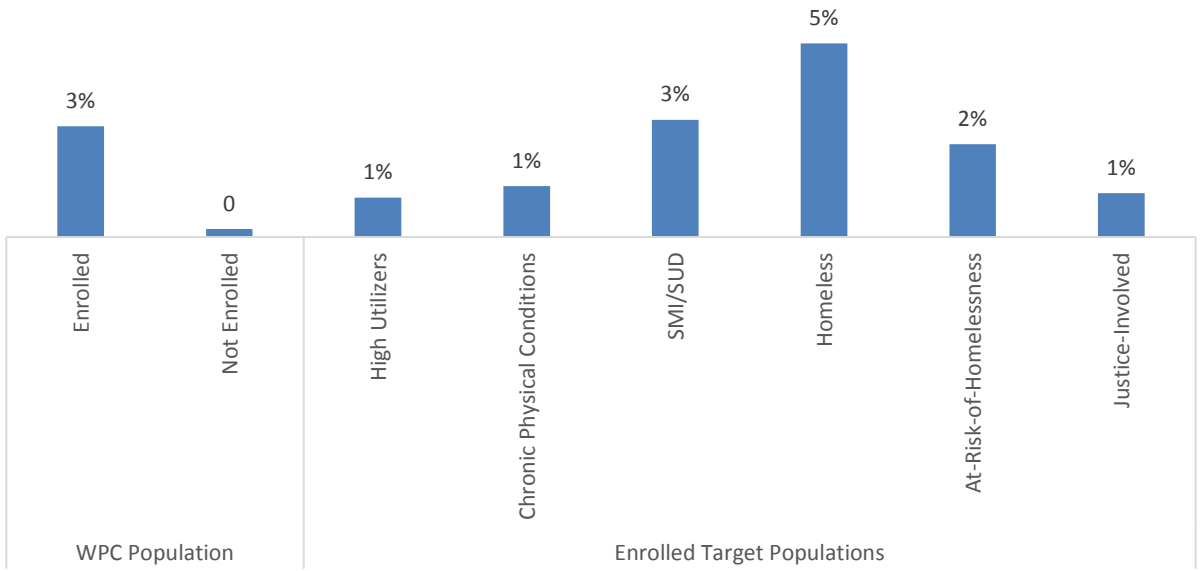
WPC Pilot	Example of Sobering Center Services
Contra Costa	Contra Costa included a 24/7 sobering center in order to provide a safe environment for uncomplicated, acute intoxicated individuals to receive detoxification services along with comprehensive care services such as basic hygiene, identification and management of urgent care needs, transportation, etc.
Los Angeles	Los Angeles provided onsite services such as medical triage, point of care lab testing, client beds, oral rehydration and food service, nausea treatment, wound care and dressing changes, shower and laundry facilities, substance use counseling, and linkage to health and behavioral health services.

Source: WPC Applications, WPC Mid-Year and Annual Narrative Reports, and Follow-up Interviews with Lead Entities and Frontline Staff conducted from September 2018-March 2019.

Medical Respite

Eleven WPC Pilots (41%, Exhibit 70) provided medical respite, or acute and post-acute medical care for enrollees in unstable living situations who were not sufficiently ill to remain in a hospital or skilled nursing facility but too ill to recover without adequate shelter. Among WPC enrollees, 3% received services that included medical respite or recuperation care (Exhibit 82). Among the target populations, the homeless enrollees had the highest rate of receiving services that included medical respite or recuperation care (5%). Most Pilots utilized FFS interventions (9 of 11) rather than PMPM bundles to fund these services.

Exhibit 82: Estimated Delivery of Medical Respite Service to WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



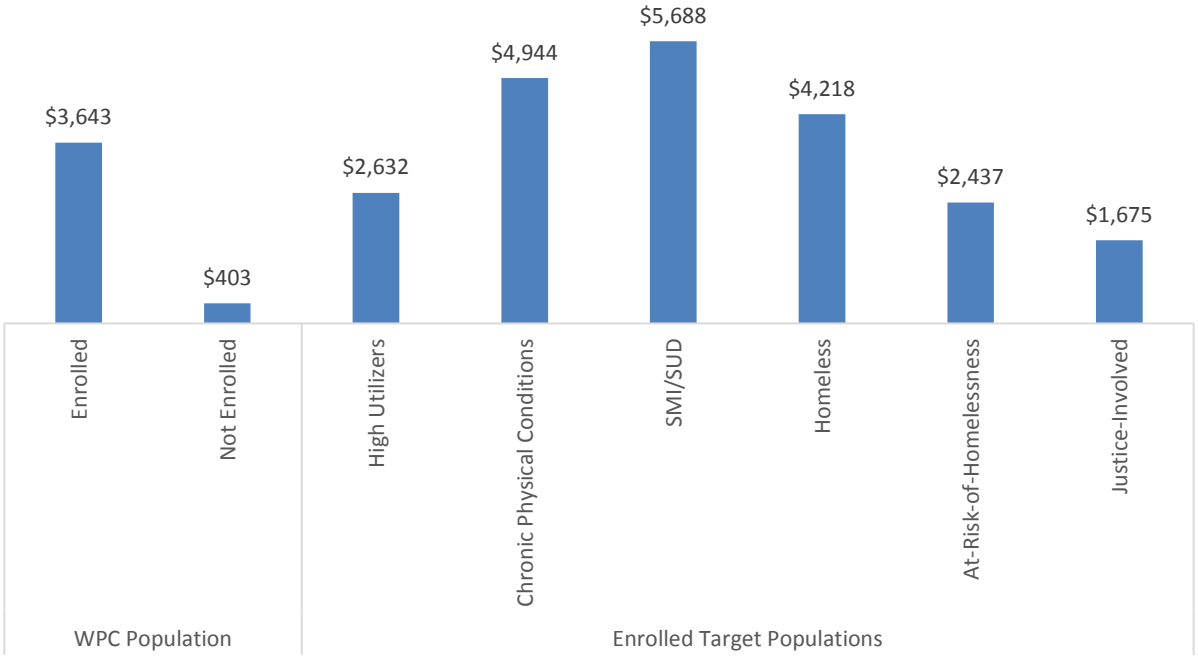
Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.

Medical respite was viewed as a critical tool for helping reduce over-utilization of ED visits and hospitalizations. Length of stay in medical respite varied considerably across Pilots. Kings provided medical respite for an average of 1-3 days, but expected enrollees to utilize the service more than once while enrolled in WPC, while Ventura estimated an average enrollee length of stay at 12 days. By contrast, multiple other Pilots (Orange, Los Angeles, Placer, San Francisco, and San Joaquin) permitted stays of up to three months.

Estimated Payment for Service Category per Enrollee

UCLA calculated the estimated average payment for WPC categories of services delivered using the PMPM and FFS service payment amounts per individual reported in *WPC Enrollment and Utilization Reports*, (Exhibit 83). On average, WPC Pilots received $3,643 per enrollee and $403 per individuals that did not enroll in WPC. Average payments for SMI/SUD enrollees was highest at $5,688, followed by chronic physical conditions ($4,944) and homeless ($4,218) enrollees. The target populations with the lowest average payment was the justice-involved enrollees ($1,675).

Exhibit 83: Estimated Average Payment of Services for WPC Enrollees by Enrollment Status and Target Population, January 2017 to December 2018



Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 122,886 unique individuals that received services through WPC: 108,667 enrolled and 14,219 never enrolled. SMI/SUD is severe mental illness and/or substance use disorder.
Average service cost was calculated by summing the total costs of all fee-for-service interventions or per-member per-month intervention bundles each individual received from WPC and dividing by the total number of individuals receiving services

Chapter 8: Care Coordination

A major goal of WPC was to "increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries." This chapter addresses the following evaluation questions: "to what extent did WPC Pilots (a) improve comprehensive care coordination, including in-real-time coordination, across participating entities; and (b) achieve the approved application deliverables relating to care coordination?" and "what key factors aided or hindered the success of specific strategies in implementing or achieving the intended outcomes, and what measures are WPC Pilots taking to address these barriers?"

Data sources for this chapter include interim WPC Pilot surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots. Data from Pilots and the 25 applications and narrative reports submitted to DHCS were also included in the following analyses. For additional detail on data sources and methodology please see the Analytic Methods and Appendices C, D and E.

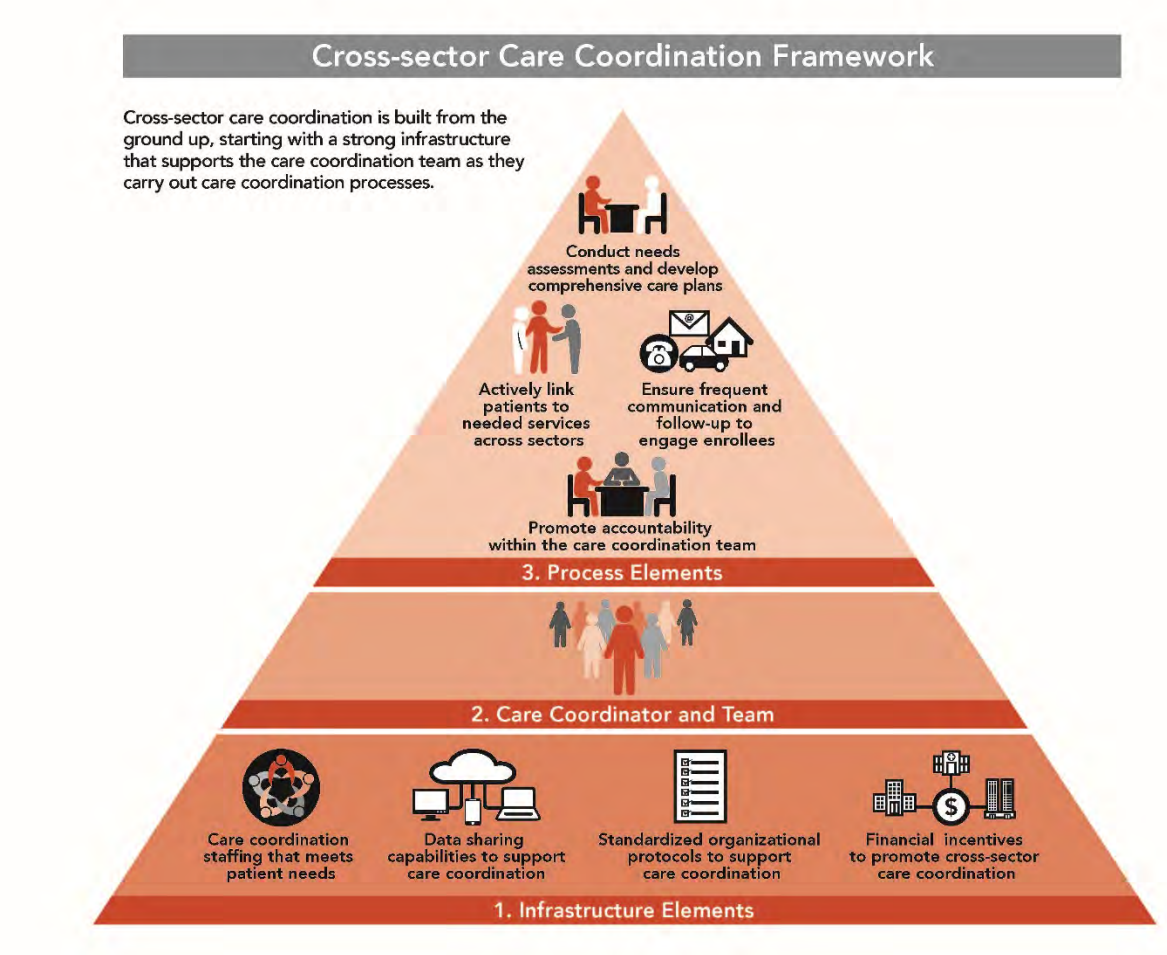
A Conceptual Framework for Assessment of WPC Care Coordination

Definitions of care coordination can vary across sectors. [1] The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." [2] When interviewed about their definitions of care coordination, several Pilots described the need to reconcile differing definitions across partners prior to implementing WPC. Other Pilots noted the decision to expand beyond care coordination and also offer case management to clients. However, the majority of Pilots also identified care coordination definitions and associated activities generally consistent with the AHRQ definition.

Informed by the AHRQ definition, our interviews with Pilots, and a review of the literature on cross-sector care coordination, UCLA developed a conceptual framework that identified key elements needed for effective care coordination under WPC (Exhibit 84). This framework included infrastructure needed to support effective care coordination, as well as specific care coordination processes. Infrastructure elements included: (1) care coordination staffing that meets patient needs, (2) data sharing capabilities to support care coordination, (3) standardized organizational protocols to support care coordination, and (4) financial incentives to promote cross-sector care coordination. Care coordination processes included: (5) ensuring frequent communication and follow-up to engage patients, (6) conducting needs assessments and develop comprehensive care plans, (7) actively linking patients to needed services across

sectors, and (8) promoting accountability within the care coordination team. We used this framework to assess Pilots' progress in implementing care coordination under WPC in the Care Coordination Policy Brief and Pilot Case Studies.

Exhibit 84: WPC Cross-Sector Care Coordination Framework



Source: UCLA Care Coordination Policy Brief, 2019.

Progress in Implementing Care Coordination

As indicated in the Care Coordination Policy Brief and Pilot Case Studies, WPC Pilots made significant progress in building needed infrastructure and in the delivery of care coordination services. By mid-2018, most Pilots had developed a functional care coordination program staffed by care coordinators; implemented at least some mechanisms for data sharing; developed standardized care coordination protocols; and established financial incentives for effective performance. Additionally, Pilots had implemented a variety of approaches to engage enrollees in care; provided comprehensive care plans for enrollees; actively linked enrollees to services; and created structures to encourage accountability among care coordination teams.

In surveys, on a scale of 0 (not at all) to 10 (very much), participating Pilot lead entities and partner organizations indicated that WPC improved coordination of care (average rating of 7.6 by lead entities and 7.1 by partner organizations), and continuity of care (average rating of 7.2 by lead entities and 6.9 by partner organizations) for WPC enrollees. Below we present selected examples of care coordination infrastructure and processes implemented by Pilots. Additional details and a full summary of Pilots' progress are included in the Care Coordination Policy Brief and Pilot Case Studies.

Care Coordination Infrastructure

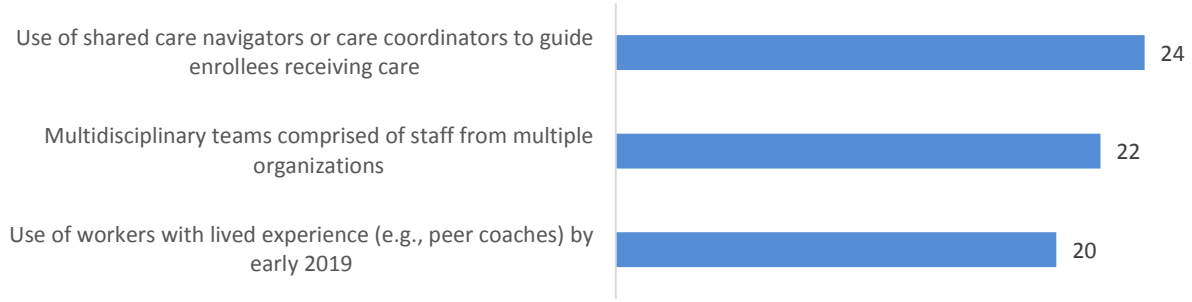
Care Coordination Staffing that Meets Patient Needs

In surveys, Pilots reported use of multidisciplinary teams comprised of staff from multiple partners (22 of 27), and reported use of shared care coordinators or navigators to deliver care coordination services (24, Exhibit 85). Care coordination services were often provided by non-clinical staff such as community health workers, in consultation with or under the supervision of staff with clinical expertise such as physicians, nurses, or social workers. According to case studies, by early 2019, most Pilots also reported using workers with lived experience relevant to enrollees, such as peer coaches (20 of 26).

Average caseload ranged from approximately 10, to over 100 enrollees per care coordinator depending on the structure of the program and the needs of the enrollees. Median caseload was approximately 20 to 30 enrollees per care coordinator (data not shown).

> *"I know that peer support has been around for years and almost every agency but I do like how this is pretty much like the whole program is them instead of them just being ancillary to case managers."*
>
> *– Los Angeles*

Exhibit 85: Care Coordination Staffing Approaches Used by WPC Pilots



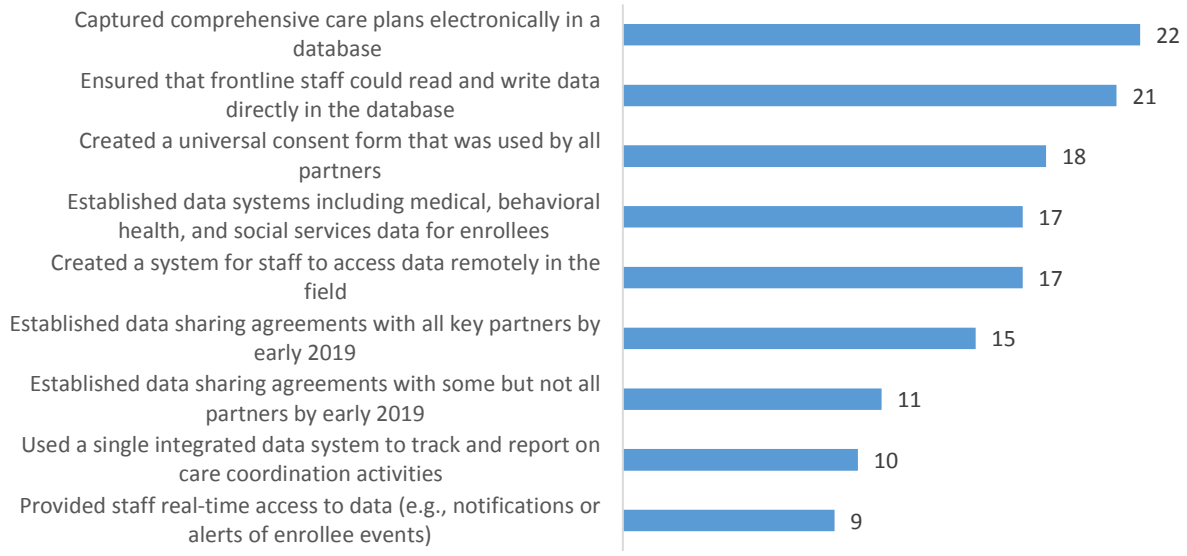
Source: Whole Person Care Pilot Survey (n=27), June-September 2018; and Case Studies (n=26), 2019.

Data Sharing Capabilities to Support Care Coordination

By early 2019, results from case studies indicated that all Pilots had established data sharing agreements with at least some partners, and over half of Pilots had successfully done so with all key partners (15 of 26, Exhibit 86). Most Pilots had also created a universal consent form that was used by all partners to facilitate sharing of enrollee data (18), and had captured enrollees' comprehensive care plans electronically in a database (22). However, fewer Pilots used a single integrated data system to track and report on care coordination activities (10), or had sufficiently developed infrastructure to provide staff with real-time notifications or alerts of enrollee events such as hospital utilization (9).

In surveys, over a third of Pilots reported that they electronically shared enrollee information with partners or through a health information exchange prior to participating in WPC (10 of 27, data not shown). However, in interviews, most Pilots also highlighted a need to develop substantial data sharing infrastructure after WPC began, and identified data and information technology infrastructure as a strategic priority. In surveys, on a scale of 0 (not effective) to 10 (extremely effective), participating organizations identified WPC as effective at increasing data sharing between their organizations (average rating of 7.0, data not shown).

Exhibit 86: Number of WPC Pilots Participating in Select Data Sharing Capabilities to Support Care Coordination



Source: Whole Person Care Pilot Survey (n=27), June-September 2018; and Case Studies (n=26), 2019.

Exhibit 87 provides selected examples of data and information sharing infrastructure developed by Pilots as part of WPC, and how this infrastructure was used to facilitate care coordination activities.

Exhibit 87: Selected Examples of Data System Types Implemented in WPC

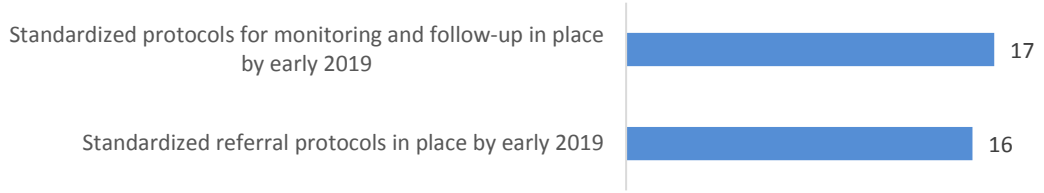
Data System Type	WPC Pilot	Selected Examples
Single centralized system	Contra Costa Kings Marin Mariposa (SCWPCC) Monterey Orange San Benito (SCWPCC) San Bernardino San Diego Solano	Kings provided all partner organizations with access to an electronic case management platform (called ETO) to view enrollees' comprehensive care plans. Care coordinators used ETO to perform and track all care coordination activities. Data included in ETO was comprehensive, and included medical, behavioral health, and social services data from the county's behavioral health and human services agencies and the community-based partners responsible for care coordination. Care coordinators could access the system in the field, but did not typically receive real-time updates about enrollee service utilization.
		Marin implemented an electronic care coordination platform to provide partners with access to enrollee data, including the comprehensive care plan, and help track care coordination activities. The platform included an internal messaging tool with chat functions to facilitate communication between providers. Care coordinators were able to access the platform in the office and in the field.
Multiple systems	Alameda Kern Los Angeles Mendocino Napa Placer Riverside Sacramento San Francisco San Joaquin San Mateo Santa Clara Santa Cruz Shasta Sonoma Ventura	Placer's care coordinators used two electronic databases. An electronic health record (Avatar) was used to manage enrollee health, behavioral health, and social service data. An electronic system called PreManage was used to track care coordination activities, including the care plan, and provide care coordinators with real-time notifications when enrollees received hospital or emergency department services. Some partners directly accessed information in PreManage while others contacted care coordinators for relevant information. As of early 2019, Placer started moving all tracking activities to Avatar only, but still used PreManage to receive real-time notifications.
		Riverside used multiple electronic systems to capture information about enrollees. Nurse care managers mainly used Epic, an electronic health record, for daily care coordination activities. Partners providing care in other departments had read-only access to the Epic database. Care coordinators also had read-only access to partner agency databases containing housing and behavioral health records. In order to facilitate care coordination in the field, care coordination staff had remote access to data.

Source: Whole Person Care Case Studies (n=26), 2019.
Note: SCWPCC is the Small County Whole Person Care Collaborative.

Standardized Organizational Protocols to Support Care Coordination

Developing standardized procedures and protocols to support care coordination was a priority for some, but not all Pilots. In surveys, less than half of Pilots reported that prior to WPC they had standardized protocols in place for referring enrollees to services (9 of 27, data not shown). As shown in case studies, WPC increased the proportion of Pilots with protocols in place, and by early 2019 over half of Pilots reported they had standardized protocols for referring enrollees to medical, behavioral health, or social services (16 of 26), or had standardized protocols for monitoring and following up on whether enrollees needed services (17, Exhibit 88).

Exhibit 88: Number of WPC Pilots Implementing Standard Organizational Protocols

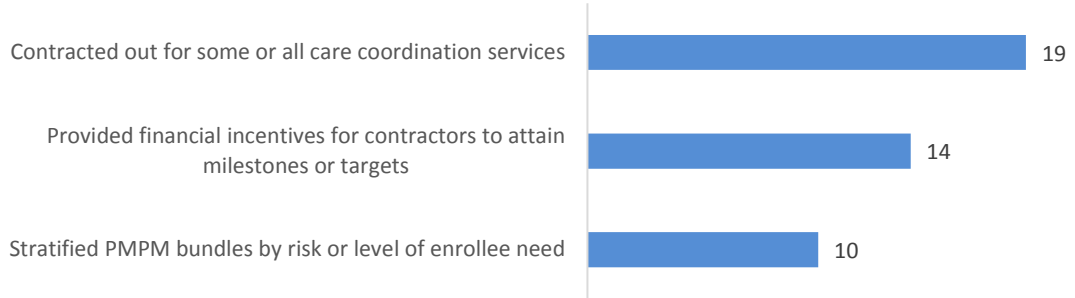


Source: Whole Person Care Pilot Survey (n=27), June-September 2018; and Case Studies (n=26), 2019.

Financial Incentives to Promote Cross-Sector Care Coordination

Results from case studies indicate that all Pilots used per-member-per-month (PMPM) funding to support care coordination activities (data not shown). Just under half established PMPM bundles that were stratified by the risk or level of need of enrollees (10 of 26, Exhibit 89). Most Pilots contracted out some or all care coordination services for delivery by partner organizations (19); the remaining Pilots delivered care coordination services in-house, and did not contract out to partners. Approximately half of Pilots provided financial incentives to partner organizations, such as financial rewards for attaining specific milestones or performance targets (14).

Exhibit 89: Number of WPC Pilots Implementing Selected Financial Approaches



Source: Whole Person Care Case Studies (n=26), 2019.

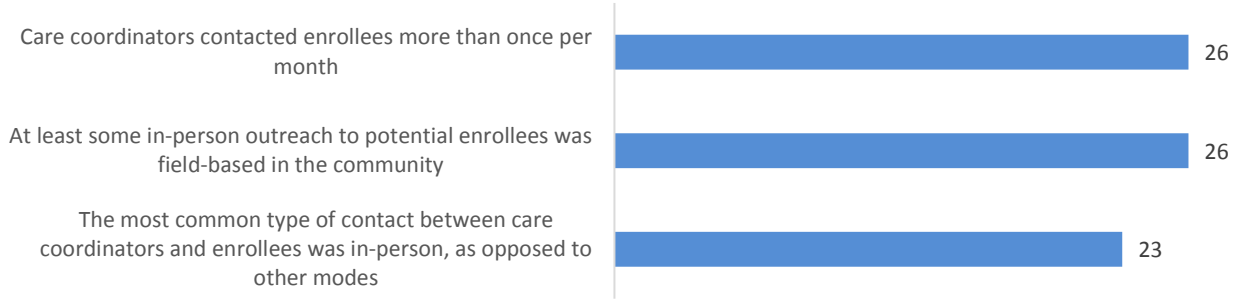
Care Coordination Processes

Ensuring Frequent Communication and Follow-Up to Engage Patients

Pilots typically described using a patient-centered approach to communication that accommodated enrollee needs and preferences. In case studies all of the Pilots (26 of 26, Exhibit 90) reported conducting at least some field-based outreach to potential enrollees in the community, and required care coordinators to regularly contact enrollees at least once per month. Nearly all Pilots (23) reported that the most common type of contact between care coordinators and enrollees was in-person, rather than by phone or other mode of communication.

Most Pilots emphasized the importance of field-based and in-person communication for engaging enrollees in WPC, particularly those experiencing homelessness (data not shown). Several Pilots required staff to communicate with high-need or high-risk enrollees more frequently or through a more intensive mode (e.g., in-person rather than by phone). Others reported helping enrollees access affordable or free phones in order to facilitate communication and follow-up. Exhibit 91 provides examples of communication and follow-up processes implemented by frontline staff, selected to demonstrate the variety of approaches.

Exhibit 90: Number of WPC Pilots Implementing Selected Communication Approaches



Source: Whole Person Care Case Studies (n=26), 2019.

Exhibit 91: Selected Examples of Communication and Follow-Up Approaches with Enrollees in WPC

Primary Mode of Ongoing Communication	WPC Pilot	Selected Examples
Ongoing communication was primarily by phone or other mode	Kern Riverside Santa Clara	Riverside's WPC Pilot used in-person contact at probation offices to initiate outreach and screen eligible enrollees for needs. Ongoing communication occurred primarily by phone, though in-person meetings and other modes such as letters were also used. As appropriate, care coordinators worked with enrollees' probation officers to determine the best way to communicate, which at times could include reaching enrollees through their friends or families.
		In Santa Clara, following enrollment and development of initial goals, communication between the enrollee and care coordinator was primarily telephonic for most clinics. Some of the community health clinics utilized a service model which included not only telephonic and clinic-based care coordination services but also conducted care coordination services in the home and/or field.
Ongoing communication was primarily in-person	Alameda Contra Costa Kings Los Angeles Marin Mariposa (SCWPCC) Mendocino Monterey Napa Orange Placer Sacramento San Benito (SCWPCC) San Bernardino San Diego San Francisco San Joaquin San Mateo Santa Cruz Shasta Solano Sonoma Ventura	Mariposa's Pilot mainly used in-person communication with enrollees, both during outreach and on-going communication. This approach was particularly important for engaging enrollees who were homeless.
		Los Angeles' Pilot used a variety of settings and modes to initiate contact with eligible enrollees across WPC-LA programs (e.g., in-person communication in jails for reentry, or in hospitals for transitions of care, etc.). The most common form of outreach was in-person, by meeting enrollees where they were (e.g., in hospital or at primary care visit). CHWs maintained contact with enrollees through a variety of mechanisms, but primarily by a mix of telephone and in-person visits.

Source: Whole Person Care Case Studies (n=26), 2019.

Notes: CHW is community health worker. SCWPCC is the Small County Whole Person Care Collaborative.

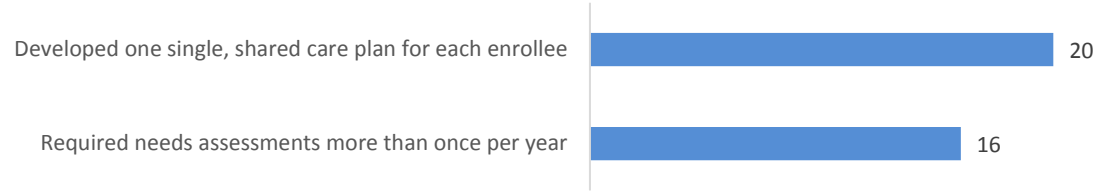
Needs Assessment and Comprehensive Care Planning Processes

To meet the requirements of participating in WPC, all WPC pilots conducted annual needs assessments to identify target population needs and evaluate individual and population health progress over time. [3] In case studies, most Pilots reported that they required a single, unified comprehensive care plan for each enrollee that was shared across partner organizations (20 of 26, Exhibit 92); the remaining Pilots implemented care plans, but had multiple types of plans or did not share them with all partners. Over half of Pilots reported that they required needs assessments to be repeated more than one time per year (16). Additionally, on a scale of 0 (not effective) to 10 (extremely effective), Pilot lead entities and partner organizations reported that WPC was effective at ensuring earlier identification of patient needs (average rating of 6.9 by lead entities and 7.2 by partner organizations).

Specific needs assessment tools and their comprehensiveness varied, particularly when it came to evaluating social needs. Pilots also varied in whether they administered formal needs assessments once per year, or more frequently. Exhibit 93 provides examples of needs assessment approaches and tools used by certain Pilots, organized by frequency with which assessments were conducted.

> *"And that includes identifying physical health needs, including palliative care, functional health, cognitive behavioral health needs, both mental health and substance use, social determinants of health housing. So all of those things are considered essential to the comprehensive risk assessment."*
>
> *– Alameda*

Exhibit 92: Number of WPC Pilots Implementing Selected Assessment and Planning Activities



Source: Whole Person Care Case Studies (n=26), 2019.

Exhibit 93: Selected Examples of WPC Enrollee Needs Assessment Strategies

Assessment Frequency	WPC Pilot	Selected Examples
Typically assessed enrollee needs once per year	Contra Costa Marin Mendocino Orange Placer San Bernardino San Mateo Santa Cruz Shasta Sonoma	Santa Cruz's case managers performed a formal needs assessment at intake, which was then repeated annually or whenever a significant change in the enrollee's life occurred. Needs assessment included the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), informal psychosocial assessments and other additional assessments needed to develop a comprehensive care plan with client-driven goals.
		Shasta's care coordinators performed a formal needs assessment at intake. A case manager, a nurse, and a housing manager each conducted their own assessments to inform the care plan. Assessments included a PHQ (Patient Health Questionnaire)-9 screening for depression and a suicide risk assessment tool. Assessments directly informed the acuity level determination and tier placement of enrollees; assessments were conducted annually.
Typically assessed enrollee needs more than once per year	Alameda Kern Kings Los Angeles Mariposa (SCWPCC) Monterey Napa Riverside Sacramento San Benito (SCWPCC) San Diego San Francisco San Joaquin Santa Clara Solano Ventura	In San Francisco, through the use of a universal assessment tool, enrollees were prioritized and assigned a care coordinator. Care coordinators performed a formal needs assessment at intake and assured that service-specific intakes were completed. Assessments were repeated at minimum once per year, but usually quarterly or as enrollee circumstances changed.
		Ventura's care coordinators performed a formal needs assessment at intake, and annually thereafter, with an updated nursing assessment every 90 days. In addition, all enrollees with a recent emergency department or hospital visit received a weekly comprehensive case review that was made available to care coordinators in the electronic health record.

Source: Whole Person Care Case Studies (n=26), 2019.
Note: SCWPCC is the Small County Whole Person Care Collaborative.

Actively Linking Patients to Needed Services Across Sectors

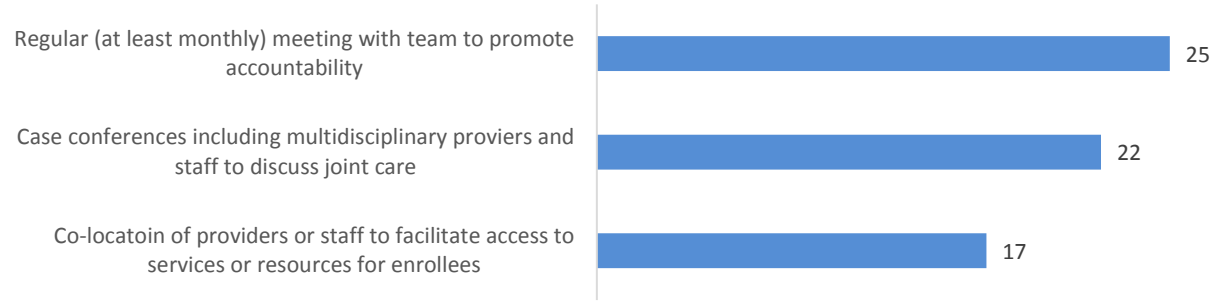
Linking enrollees to services to meet their health and social needs was a foundational component of care coordination in all WPC Pilots. In interviews and surveys, all Pilots reported using active referral strategies with enrollees, such as helping enrollees schedule appointments, accompanying enrollees to appointments, assisting enrollees with transportation, and following up with enrollees after appointments for medical, behavioral health, and social services (data not shown).

> *"We kinda find out what's going on across the board with that person, whether it's mental health, substance abuse treatment, or physical health, or they have food insecurities, or housing insecurities, or shelter insecurities. We look at all of that and what's going on with that person, and then we try to link them up to what best works for them and what's going on in their life."*
>
> *– Kings*

Promoting Accountability Within the Care Coordination Team

In surveys, many Pilots reported co-locating providers or staff with partner organizations to facilitate access to services and resources for enrollees (17 of 27, Exhibit 94), and holding case conferences including multidisciplinary providers and staff to discuss joint care (22). In early 2019, nearly all Pilots reported that their care coordination teams convened at least once a month to discuss enrollee needs (25). WPC Pilots developed a variety of strategies to facilitate communication, transparency, and accountability for follow-through among members of their care coordination teams. The primary way that Pilots held team members accountable was through modes of communication that were common in many professional environments. Most Pilots held regular in-person meetings for care coordination staff, but also used phone calls, emails, and sometimes text messages when permitted. Exhibit 95 illustrates the variety of strategies used by Pilots to promote accountability among care coordination teams.

Exhibit 94: Number of WPC Pilots Engaging in Selected Strategies to Increase Care Coordination Team Accountability



Source: Whole Person Care Pilot Survey (n=27), June-September 2018; and Case Studies (n=26), 2019.

Exhibit 95: Selected Examples of Team Accountability Strategies in WPC

Type of Accountability Strategy	WPC Pilot	Selected Examples
Emphasis on communication at in-person meetings	Alameda Contra Costa Kern Kings Los Angeles Marin Mariposa (SCWPCC) Mendocino Monterey Napa Orange Placer Riverside Sacramento San Benito (SCWPCC) San Bernardino San Diego San Francisco Santa Clara Santa Cruz Shasta Solano Sonoma Ventura	Napa's Pilot required meetings and other forms of communication between partners and providers to coordinate care, in part because they did not yet have an electronic care coordination platform. The coordinated entry system held a housing meeting every other week with many of the key WPC service providers to discuss individuals with the highest needs. Additionally, each organization had weekly case management and care coordination meetings to receive updates on enrollee progress and discuss any service needs or challenges faced by the enrollees.
		In Kern, to promote accountability, the WPC manager checked in with staff at least daily and held a weekly WPC meeting where the care coordination team could openly discuss enrollment, goals, and challenges. Additionally, the team communicated regularly through email.
Emphasis on communication outside of meetings	San Joaquin San Mateo	In San Joaquin, care coordinators typically communicated with one another through email, phone calls, and secure messaging. The Pilot did not require care coordinators to participate in regular, cross-disciplinary case conferencing meetings. However, senior and mid-level staff in relevant WPC partner organizations did participate in regular, quarterly meetings to discuss the Pilot and identify strategies for improving care coordination processes.
		In San Mateo, most care navigators were required to complete a daily progress note each time they contacted an enrollee. Across teams, care navigators reported frequently calling and emailing other teams to discuss enrollee needs; however, these activities were informal and the Pilot did not require participation in regular, in-person across team meetings. Within teams, regular weekly, in-person meetings were held. Additionally, progress notes and treatment plans were available to all team members and supervisors to increase accountability within teams.

Source: Whole Person Care Case Studies (n=26), 2019.

Note: SCWPCC is the Small County Whole Person Care Collaborative

Challenges and Solutions

In narrative reports, WPC Pilots were asked to report challenges to implementing care coordination. Almost all WPC Pilots (96%, 24 of 25) described care coordination challenges related to limited availability and/or accessibility of services for enrollee referrals (Exhibit 96). WPC Pilots most commonly referenced housing-related issues, including: long wait times for existing permanent housing stock; limited housing options available within the county; poor quality and fit for enrollees among the available housing units; and how the lack of housing prevented other desired health and social outcomes among enrollees. Additionally, WPC Pilots discussed limited availability and accessibility of behavioral health services within county limits.

Exhibit 96: Commonly Identified Challenges in Care Coordination Among WPC Pilots, January 2017-December 2018

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the four reports (N=93).

Nearly all WPC Pilots (92%, 23) identified difficulty engaging appropriate interdisciplinary partners in program implementation as a barrier to care coordination. For example, multiple WPC Pilots reported that partners were unwilling or hesitant to engage due to their competing priorities with other programs or initiatives. Initially, WPC Pilots mentioned limited trust and buy-in from partners to the WPC program.

Over three-fifths of WPC Pilots (64%, 16) identified staffing issues including recruitment, training, retention, and turnover as a barrier to care coordination. Multiple WPC Pilots explicitly attributed staffing challenges to cumbersome county hiring and/or contracting processes such

as background checks or requirements for open search that made it difficult to quickly fill key administrative and/or frontline positions. These challenges required WPC Pilots to plan far ahead when developing project timelines, which was challenging early in the implementation process.

More than half of WPC Pilots (52%, 13) reported enrollees, partners, and the community experienced some difficulty in differentiating WPC from other programs providing similar services and/or seeking to accomplish similar goals. Care coordination and case management services were often offered through a variety of agencies and organizations, such as behavioral health departments and managed care plans, which created confusion regarding WPC scope and concern around the WPC requirement for non-duplication of services.

More than half of WPC Pilots (52%, 13) also reported challenges in understanding target populations and how to address their needs. Some WPC Pilots noted that an effective EHR was key to success, however, data collections often depended on manual data entries. Target populations were also difficult to engage with and often required repeated interactions in order for clients to begin reciprocating interest in the program.

Specific examples of challenges related to each main category in Exhibit 96 are described in Exhibit 97.

Exhibit 97: Selected Examples of Challenges in Care Coordination, January 2017-December 2018

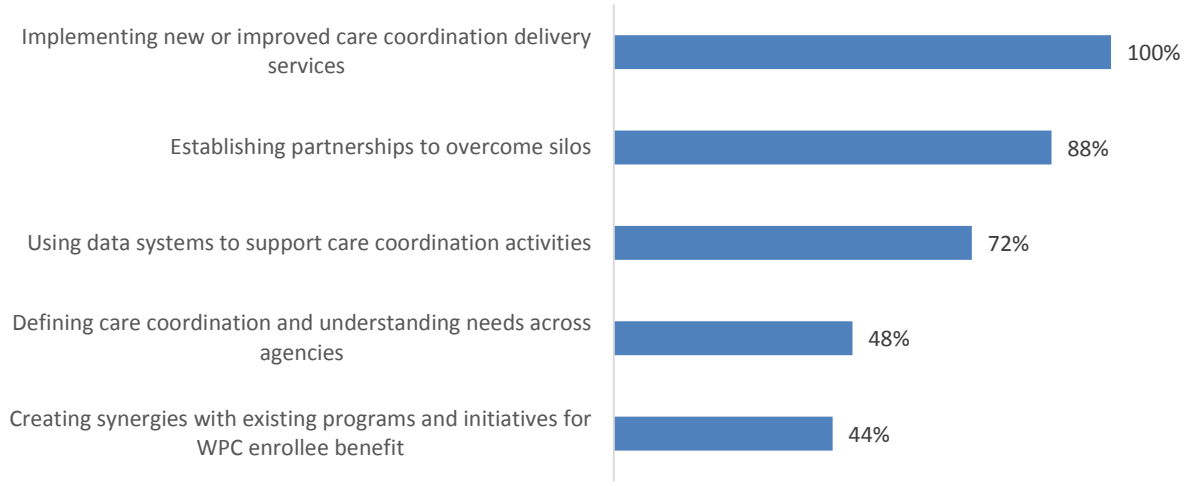
Challenge	WPC Pilot	Selected Examples
Limited availability and/or accessibility of services being coordinated	San Francisco	San Francisco emphasized the challenge of not having culturally appropriate services available to connect enrollees to in the first place. San Francisco believed traditional health and social services within large systems of care were often not the “right fit” for homeless enrollees.
	Shasta	Shasta noted the lack of medical and behavioral respite facilities in their area. Enrollees who didn’t require intensive inpatient services and were discharged were sometimes unprepared to live independently. Shasta mentioned that increased access to appropriate respite care would narrow a gap in service.
Engaging appropriate interdisciplinary partners in program implementation	Placer	Placer faced difficulties engaging with one of their partners. A lack of clear communication, such as unanswered calls, delayed opportunities to schedule appointments. Placer found some progress after communicating with various levels of management, but progress remained slow.
	Sonoma	Sonoma faced challenges in building relationships with partners and navigating the local political climate in order to accomplish care coordination activities.
	Santa Clara	Santa Clara identified challenges with ensuring accountability given the numerous agencies and departments involved in their WPC Pilot. Standardization of services, processes, and communication strategies helped to facilitate partner engagement, but Santa Clara still cited

Challenge	WPC Pilot	Selected Examples
		ongoing challenges coordinating across partners and gaining partner buy-in.
Staffing issues	Los Angeles	Los Angeles described complex hiring and contracting policies within their county as inhibiting their ability to rapidly build program capacity and onboard staff.
	SCWPCC	San Benito and Mariposa discussed the difficulty in recruiting and retaining skilled professionals in rural geographic locations.
	Santa Cruz	Santa Cruz faced challenges in recruiting staff with the skills and interest necessary to address the needs of various target populations. Santa Cruz noted that a high cost of living, proximity to Silicon Valley, and staff burnout continued to slow the program's progress.
Differentiating WPC from other programs serving similar population(s) and/or seeking to accomplish similar goals	Sacramento	When Sacramento began outreach and engagement efforts to prospective enrollees, they quickly learned that prospective enrollees did not understand how their WPC Pilot Program differed from other navigation programs offered by city and county housing providers, hospitals, and community clinics.
	Santa Cruz	Santa Cruz encountered challenges managing the interactions of various case management programs situated in the community and within their own Health Services Agency. The presence of multiple case management programs led to confusion, as well as fear of duplication and competition for scarce resources amongst participating agencies.
Understanding the population and how to address its needs	Kern	Kern noted that the transient nature of their target population made it difficult to successfully contact enrollees who needed their care coordination services. As a result, opportunities to build a relationship with enrollees and improve their health were lacking.
	Kings	Kings encountered difficulties conducting accurate screenings given that the screening tools sometimes asked personal and/or embarrassing information. Kings noted that some adults weren't comfortable completing screenings when children were present.
	Sonoma	Sonoma faced challenges obtaining consents with enrollees. Sonoma sought to build rapport with enrollees by explaining the benefits of the program and how their information will be used.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.
Notes: FQHC is a Federally Qualified Health Center. SCWPCC is the Small County Whole Person Care Collaborative.

WPC Pilots were asked to report solutions in implementing care coordination. The five most common themes that emerged from Pilot descriptions of solutions were: (1) implementing new or improved care coordination delivery services; (2) establishing partnerships to overcome silos; (3) using data systems to support care coordination activities; (4) defining care coordination and understanding needs across agencies; and (5) creating synergies with existing programs and initiatives for WPC enrollee benefit (Exhibit 98).

Exhibit 98: Commonly Identified Solutions in Care Coordination Among WPC Pilots, January 2017-December 2018



Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.
Note: Percentages indicate the proportion of the 25 WPC Pilots that mentioned the thematic challenge at least once in any of the four reports (N=93).

All WPC Pilots (100%, 25 of 25) reported solutions related to implementation of new or improved care coordination services; many of these efforts focused on improvements in the day-to-day activities of frontline staff. Commonly identified examples of solutions within the delivery of care coordination services included: organizing regular case conferences with partners and managed care plans to discuss high-need enrollees; prioritization of services or housing for WPC enrollees including reserved appointments, set-aside vouchers; and effective communication across the entire care team.

Almost all WPC Pilots (88%, 22) reported solutions in establishing partnerships to overcome silos. Frequently WPC Pilots described working with partners in new ways that improved understanding of mutual goals for shared clients (e.g., warm handoffs of enrollees after an ED visit, direct communication through electronic platforms). WPC Pilots emphasized proactive and consistent communication amongst partners, and formalized contracts to facilitate implementation of care coordination activities among partners with historically limited interaction.

Roughly three-fourths of WPC Pilots (72%, 18) had solutions related to using data systems to support care coordination activities. Many WPC Pilots reported having procured or being in the process of procuring care management platforms, which helped to streamline important care coordination activities and share relevant enrollee information amongst multiple users involved in the enrollee's care.

About half of WPC Pilots (48%, 12) reported solutions in defining care coordination and understanding care coordination needs across agencies including alignment of enrollee assessment tools across partners, tracking of metrics, and establishment of referral pathways. Several WPC Pilots developed formal and shared definitions within their partner networks for care coordination that outlined specific responsibilities by agency. Often this was facilitated by the WPC Pilot initiating an opportunity such as organizing a meeting or listening session for partners to work together to develop a common definition or list of required care coordination activities.

Over two-fifths of WPC Pilots (44%, 11) reported solutions for WPC enrollees as a result of effectively utilizing synergies with existing programs and initiatives, particularly because many programs have similar goals and provide care to the same populations. Typically, these solutions involved the Pilots working with other programs to identify and delineate their respective roles and responsibilities with those WPC enrollees.

Specific examples of solutions related to each main category in Exhibit 98 are described in Exhibit 99.

Exhibit 99: Selected Examples of Solutions in Care Coordination Among WPC Pilots, January 2017-December 2018

Solution	WPC Pilot	Selected Examples
Implementing new or improved care coordination delivery services	Contra Costa	Contra Costa developed a case manager training curriculum to standardize case manager onboarding training. The curriculum was designed to improve the program's efficiency in delivering coordinated services to enrollees.
	San Bernardino	San Bernardino held monthly "Whole Person Care Accountability Review" (WAR) conferences (i.e., detailed, complex case reviews) with the program manager. In these meetings, each enrollee was individually studied and discussed amongst the care team. WAR conferences have been successful in developing individual action plans and identifying barriers to care, such as inefficient communication pathways.
	Ventura	Ventura had a daily huddle to support team-based care. In the daily huddle, teams reviewed new enrollees, integrated care plans, recent ED visits and hospital discharges, and priority and "stuck" cases. Additionally, the huddles provided an opportunity for on the spot training for brief topics, as issues arose in the field.
Establishing partnerships to overcome silos	Marin	Marin developed a strategic partnership with their local housing authority to set aside vouchers dedicated to WPC enrollees referred through the coordinated entry system.
	Orange	Orange created a WPC website and central email "mailbox" to address issues as they arose and provide guidance to participating partners. This simple tool has allowed coordination across programs and organizations.
	Sonoma	Sonoma partnered with various organizations and agencies such as: homeless shelters, health clinics, probation, and law enforcement. Their

Solution	WPC Pilot	Selected Examples
		partnerships allowed them to streamline services for enrollees and ensured there was no reduplication of services.
Using data systems to support care coordination activities	Contra Costa	Contra Costa developed a case management platform within their EHR. Case managers accessed documentation and care plans directly from EHR system, and all providers had access to enrollee and case manager contact information. This coordinated documentation module ensured care coordination across all systems of care.
	Orange	Orange utilized WPC Connect to centralize enrollee information. The electronic system allowed Orange to alert an enrollee's care team of a hospital visit, document an enrollee's medical history and progress, and better coordinate care for the enrollee.
	Santa Cruz	Santa Cruz used their County's long established Health Information Exchange (HIE) to adapt the system's existing case management and referral management application to support the specific needs of their Pilot.
Defining care coordination and understanding needs across agencies	Alameda	Alameda conducted group listening sessions with their partners to examine challenges and identify opportunities to develop successful care coordination methods.
	San Mateo	San Mateo developed a formal definition of care coordination that was approved by the operating committee for use across the entire San Mateo Health System.
	Sonoma	Sonoma pursued efforts to educate their community and build the infrastructure necessary for WPC to succeed. They held meetings with their communities, partnering agencies, and providers about WPC prior to implementing WPC in various communities.
Creating synergies with existing programs and initiatives for WPC enrollee benefit	San Diego	San Diego worked with their managed care plans to develop a "Care Coordination Matrix" which defined how each health plan provided care management and identified people for inclusion in their care management programs. The matrix also included key contact information for individual care management services. This tool assists in ensuring coordinated care across WPC and the individual health plans.
	San Mateo	In San Mateo, complex case conferences revealed and resolved overlap in services offered by the care coordination team and Full Service Partnerships (FSPs), a separate service that provides comprehensive mental health services for adults diagnosed with SMI. It was determined that San Mateo would assign enrollees who were connected to FSPs a WPC care coordinator only if there was a need. In addition, the FSP programs could receive care coordination support from San Mateo as needed for specific cases.
	Santa Clara	Santa Clara overcame challenges in data collection and sharing by improving the processes between their community partner clinics and the Secure File Transfer Protocol (SFTP). The data from the SFTP remained consistent given that it was also used for the Global Payment Program.

Sources: Whole Person Care Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual Narrative Reports.
Notes: EHR is electronic health record.

Chapter 9: WPC Performance Improvement and Program Monitoring

DHCS provided several forms of support to Pilots to promote successful implementation of WPC. DHCS contracted with several external organizations as well as provided support from stakeholder organizations, and DHCS staff to assist with preparing data and reports. Pilots were also required to engage in regular performance improvement activities and submit bi-annual Plan-Do-Study-Act (PDSA) reports to DHCS documenting Pilot-led efforts to improve metric performance. This chapter outlines the support services provided by DHCS and Pilots' perspectives on these activities.

Data sources for this chapter include WPC interim Pilot surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots. Data from PY 2 Mid-Year, PY 2 Annual, PY 3 Mid-Year, and PY 3 Annual PDSA Reports of 25 Pilots is also included in the following analyses. For additional detail on data sources and methodology please see the Analytic Methods and Appendices D, E and G.

Pilot-Initiated Quality Improvement

All Pilots were required to monitor progress on selected performance measures, and to utilize a quality improvement approach known as "Plan Do Study Act" (PDSA) to improve Pilot performance. The bi-annual Pilot reports included the PDSA activities that were implemented during that reporting period.

PDSA Types

WPC Pilots submitted several different categories of PDSAs to DHCS reflecting their WPC program goals, target populations, and infrastructure and process goals. The categories of PDSAs reported by Pilots included: (1) ambulatory care, (2) care coordination, (3) comprehensive care plan, (4) data, (5) inpatient utilization, and (6) other (as cited in WPC STCs). Sixteen Pilots conducted at least one PDSA that were long term and had different stages depending on program planning and implementations phases.

> *I think having the PDSA and quality improvement embedded in the structure of Whole Person Care has been a real benefit, and I think pushed the program to kind of have that QI framework, and it's developing that. I think it's been really positive for program development.*
>
> *-Contra Costa*

Appendix S provides examples of PDSAs by each category type. The data show that ambulatory care PDSAs typically focused on efforts to reduce use of the emergency department for ambulatory care sensitive conditions. For example, Alameda County linked patients who presented to an emergency psychiatric clinic to WPC services in order to reduce utilization. Contra Costa implemented software to reduce ED utilization and improve coordination of care for patients.

Care coordination PDSAs usually focused on how to improve coordination of care. Some elements of care coordination explored were navigation infrastructure, coordinated entry, common assessment tools used among participating entities, collection and use of social determinants data, increased access to social services. For some Pilots, like Orange, care coordination PDSAs entailed developing policies and procedures to define and make explicit the scope of care coordination activities to be implemented by staff. For other Pilots like Riverside University Health System, care coordination PDSAs entailed development of new partnerships with other organizations to help with care management and care transitions.

A third category of PDSAs were often around creation of a comprehensive care plan. Comprehensive care plans were to be developed and accessible to the entire care team to outline client goals and services once enrolled into WPC. In Monterey County for example, figuring out a means of transportation so that enrollees could meet parts of their care plan constituted one of their PDSAs in the category of compressive care plan. In this category, Ventura conducted PDSAs to improve the accessibility of the comprehensive care plans for enrollees. The goal was for comprehensive care plans to be accessible within a 30 day timeframe. This was part of a universal metric that was required for all WPC Pilots.

Data and reporting PDSAs were usually intended to improve methods for capturing and storing data, particularly as it related to reporting to DHCS. For example, Los Angeles used a PDSA to standardize their method of collecting enrollment data. A tool was created and staff were trained to reduce data entry errors and improve consistency.

Inpatient utilization PDSAs were typically projects aimed to reduce inpatient utilization. Some Pilots focused on particular target populations with high rates of inpatient utilization. For example, Kings worked to reduce inpatient utilization rates amongst patients experiencing a mental health crisis. A number of other PDSAs were completed and varied from establishing partnerships to facilitate access to community resources to how to reduce incarceration.

In follow-up interviews, some Pilots provided additional detail on the overall quality improvement activities that were not captured by information on specific PDSAs reported above. Selected examples are provided in Exhibit 100.

Exhibit 100: Selected Illustrative Examples of WPC Quality and Performance Improvement Activities

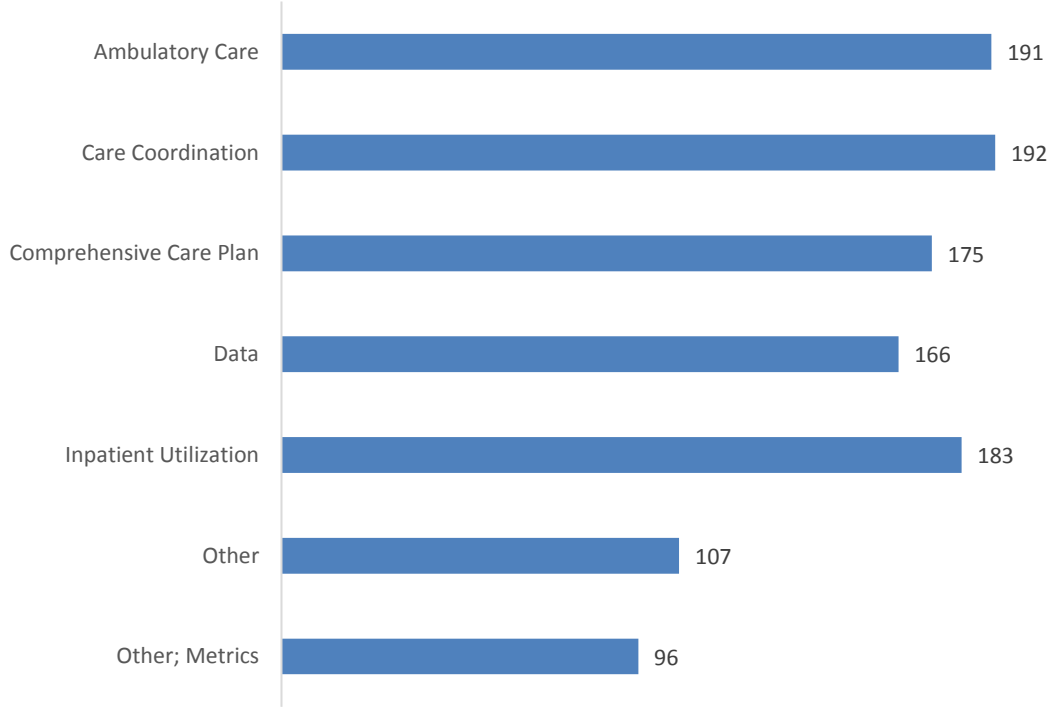
Pilot	Description/Purpose
Contra Costa	Contra Costa built and improved a data model to better provide information for case managers and supervisors. The model collected information such as the number of calls made within the past 15 days, the number of successful calls made, and the quality of documentation. Contra Costa worked with case managers and supervisors to build a dashboard to provide this information. Additionally, biweekly meetings between case managers and supervisors were held to review their work and provide feedback to staff.
Los Angeles	Los Angeles mentioned collaborative efforts with their performance improvement team to improve their workflow processes. Los Angeles also mentioned a focus on Medi-Cal enrollments and maximizing funding sources.
Santa Cruz	Santa Cruz noted a cultural shift expected in the county placing a greater focus on process improvement instead of being afraid of compliance. Santa Cruz also mentioned how WPC has helped the program take a more proactive approach towards quality improvement. They have discussed plans to train staff to more effectively use PDSA's.
Sonoma	Sonoma invited local entities such as the clinic, law enforcement, and community based providers to their monthly regional meetings. Meetings were conducted to identify challenges, successes, and discuss solutions to improve the program.

Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

Volume and Length of PDSAs Conducted by WPC Pilots

Multiple PDSAs were submitted during each reporting period across each category; the number of PDSA reports submitted to DHCS varied per WPC Pilot. Overall, 1,110 PDSAs reports were submitted to DHCS through reporting periods PY 2 Mid-Year and PY 3 Annual (January 2017-December 2018). Of those 1,110 reports submitted, the most common categories submitted included: care coordination PDSAs (17%, 192 reports), followed by ambulatory care PDSAs (17%, 191 reports) and inpatient utilization PDSAs (16%, 183 reports), due to DHCS reporting requirements (Exhibit 101). The "other; metrics" category was created based on PDSAs that were submitted that did not fit into any of the provided categories, but were metric specific. Examples of PDSAs from the "other" (general) category included projects that Pilots wished to pursue but that did not neatly fit into existing categories.

Exhibit 101: WPC PDSA Category Types across All Reporting Periods, PY 2 Mid-Year to PY 3 Annual



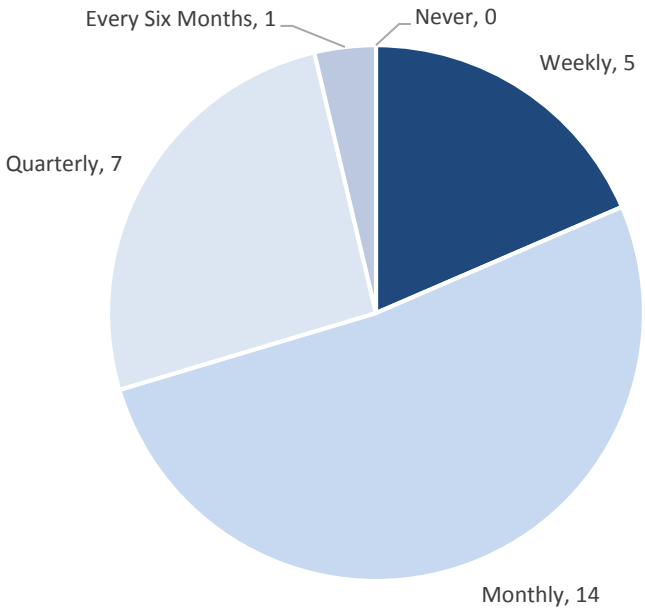
Source: Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual PDSA Reports (n=25).

Examining the length of PDSAs showed that the shortest PDSA project was 3 days and the longest was 943 days, with an average of 245 days and a median of 183 days. The length of time varied by PDSA category.

Monitoring of PDSA Activities

In the interim Pilot survey, WPC Pilots were asked to report the frequency in which they met with their partners to discuss or implement quality/performance improvement activities. Fourteen Pilots met with their partners monthly (52%) and seven met quarterly (26%) (Exhibit 102).

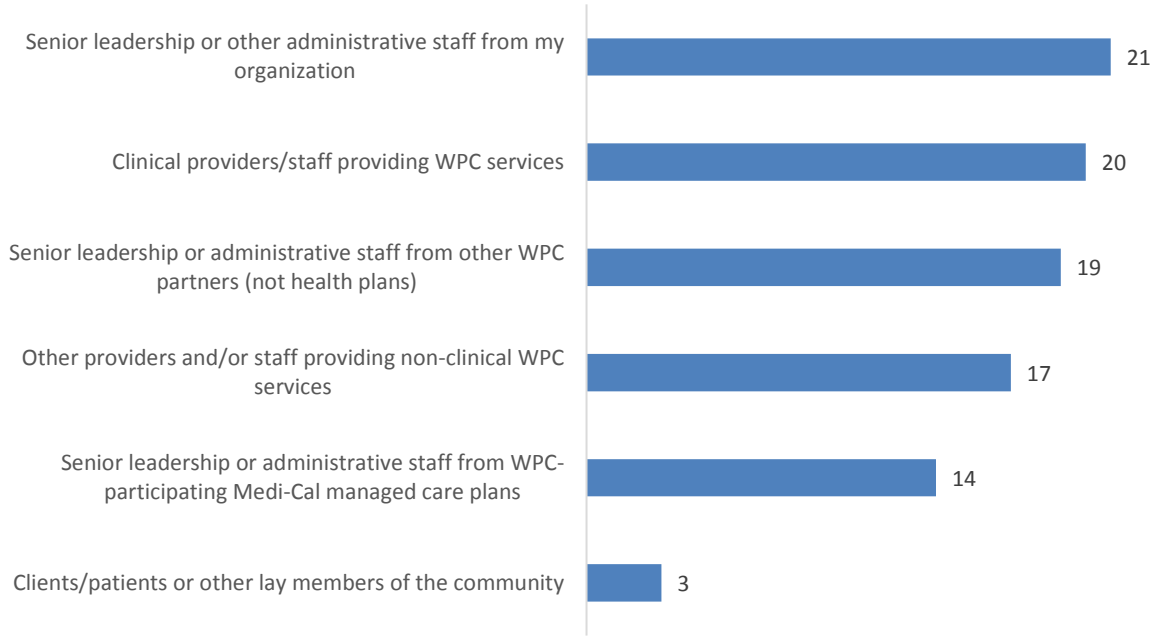
Exhibit 102: Frequency of Pilot Meetings with WPC Partners to Discuss and/or Implement Quality Improvement or Performance Improvement Activities Related to WPC



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

WPC Pilots were also asked to indicate the types of individuals involved in quality/performance improvement activities. Twenty one Pilots reported that senior leadership or other administrative staff from the Lead Entity were involved in QI activities (78%), followed by clinical providers or staff (20, 74%) and senior leadership or administrative staff from other WPC partners (19, 70%, Exhibit 103).

Exhibit 103: Types of Individuals Most Commonly Involved in WPC Quality Improvement or Performance Improvement Activities

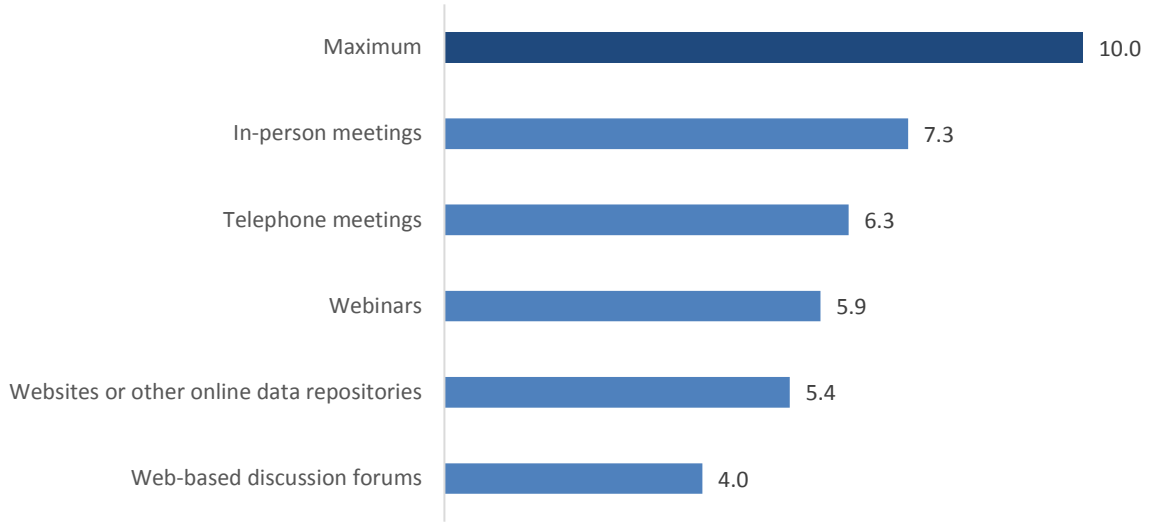


Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

In addition, DHCS contracted with two external organizations to provide Pilot-specific technical assistance as well as organize convenings for Pilots for group level technical assistance on a variety of topics. These organizations included the Center for Health Care Strategies (CHCS) and Harbage Consulting. Technical assistance (TA) opportunities provided by these organizations included activities, ranging from one-on-one consulting on Pilot-specific challenges to regional and state-wide workshops. Additional TA was provided by local stakeholder organizations such as Safety Net Institute (SNI), which assisted the Pilots with data and metric understanding, as well as County Health Executives Association of California (CHEAC), which focused on facilitating conversation amongst participating Pilots regarding shared challenges and best practices.

In the interim Pilot survey, Pilots were asked about the effectiveness of the various modalities used to receive information on a scale from 0 (not effective) to 10 (extremely effective), Pilots rated in-person meetings/convenings the highest (mean 7.3 of 10) and web-based discussion forums the lowest (4.0) (Exhibit 104).

Exhibit 104: Average Rating by Pilots Regarding Usefulness of the Following Modalities of Technical Assistance



Source: Whole Person Care Pilot Interim Survey (n=27), June-September 2018.

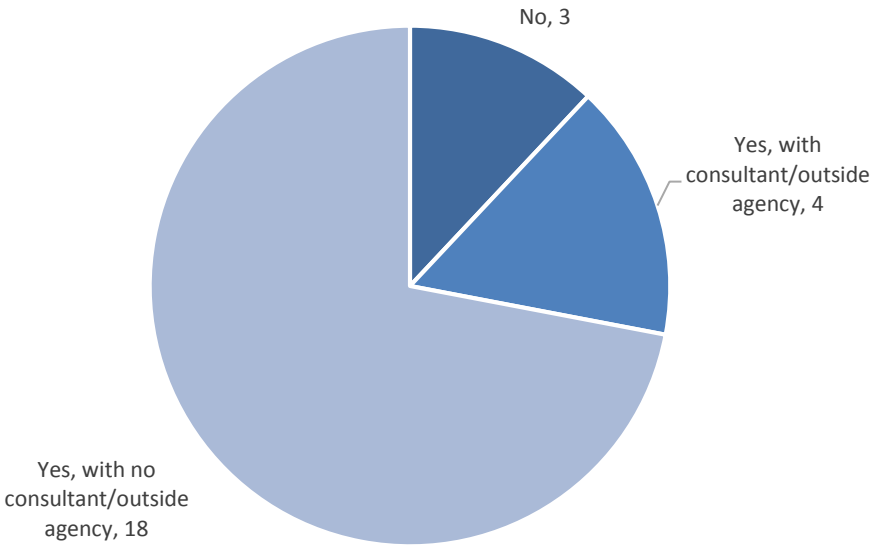
In follow-up interviews, Pilots emphasized they preferred in-person and/or telephone meetings for technical assistance services because they allowed for direct communication between Pilots and facilitated problem-solving. However, Pilots also noted that the heterogeneity of Pilot programs being implemented could limit the transferability of lessons learned.

In the interim Pilot survey, Pilots were asked to rate the usefulness of QI activities in implementing WPC and/or improving outcomes. On a scale of 0 (very low) to 10 (very high), Pilots provided an average rating of 7.0 (high; data not shown).

Internal Assessment Activities

In follow-up interviews, 22 Pilots reported conducting their own qualitative and/or quantitative internal assessments (88%) (Exhibit 105). Internal assessments ranged in degree of formality; some Pilots were planning to publish and share results of their Pilots' impact with local leaders and the community, while other Pilots planned to use the analysis for their own program monitoring and understanding. Four Pilots (16%) hired an external consultant and 18 (72%) used or planned to use WPC staff to conduct internal assessment activities. For example, Santa Cruz and Solano heavily relied on their epidemiologist to analyze WPC data for quality improvement purposes.

Exhibit 105: Internal Assessments by WPC Pilots



Source: Follow-up Interviews with Leadership and Frontline Staff (n=27), September 2018-March 2019.

Chapter 10: Enrollee Demographics, Health Status, and Prior Health Care Utilization

WPC Enrollee Characteristics

WPC Pilots were required to "receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes." This chapter addresses the following evaluation question: "What are the demographics of pilot enrollees?" In addition, UCLA examined the health status of enrollees and their utilization of services prior to enrollment in WPC. Whenever possible, this information is provided for the entire program and by target population.

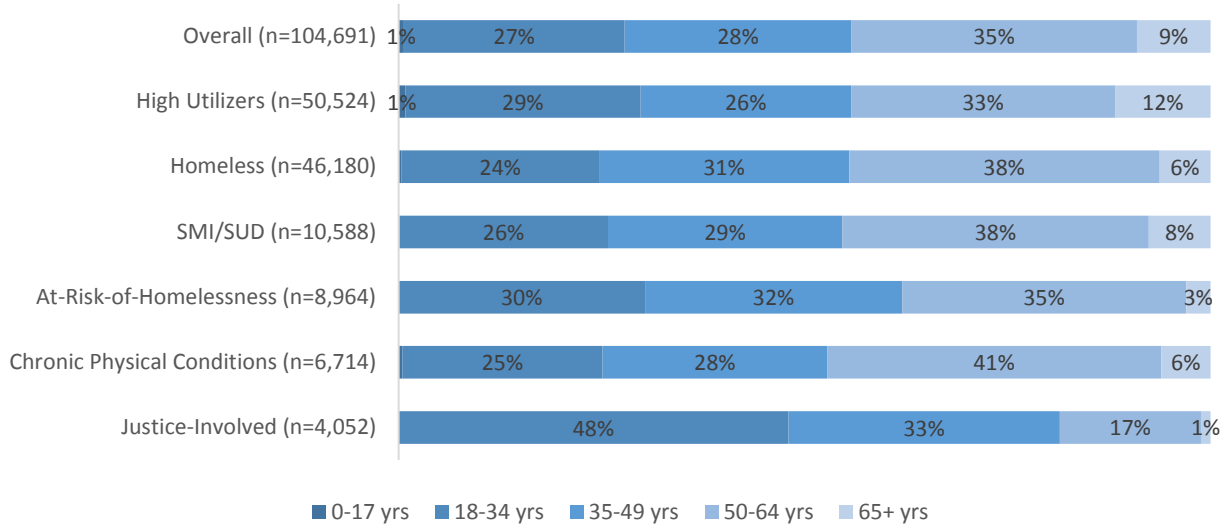
The data sources included Medi-Cal enrollment and claims data between January 2015 and December 2018 and *WPC Enrollment and Utilization Reports* from PY 2 and PY 3. Of the 108,667 WPC enrollees in PY 2 and PY 3 (2017 and 2018), 104,691 had Medi-Cal enrollment data and their demographics were analyzed. Of these, 96,868 had claims data and were included in assessment of health status and health care utilization prior to enrollment. The prevalence of chronic conditions was identified using the CMS Chronic Conditions Data Warehouse for WPC enrollees with Medi-Cal claims data, using the primary and secondary diagnosis at each encounter.

Enrollment and utilization from Medi-Cal claims data were converted by UCLA into standardized rates to facilitate comparisons across analytic groups regardless of the length of an individual's enrollment in Medi-Cal or size of an individual's target population. Utilization was calculated per 1,000 Medi-Cal member months for six-month intervals in the two years prior to an enrollees' first WPC enrollment date. For time-variant characteristics, demographic status was assessed based on the first month prior to WPC enrollment. For time-invariant characteristics, demographic status was based on the most reported value in claims between January 2015 and December 2018. Health status was assessed using PY 2 (January 2016 to December 2016) for baseline comparison. For additional detail on data sources and methodology please see the Analytic Methods.

Demographics

Medi-Cal enrollment data indicated that WPC enrollees were most often 50-64 years old (35%, Exhibit 106). The age distribution was similar for all target populations except for the justice-involved, where most often these enrollees were 18-34 years old (48%).

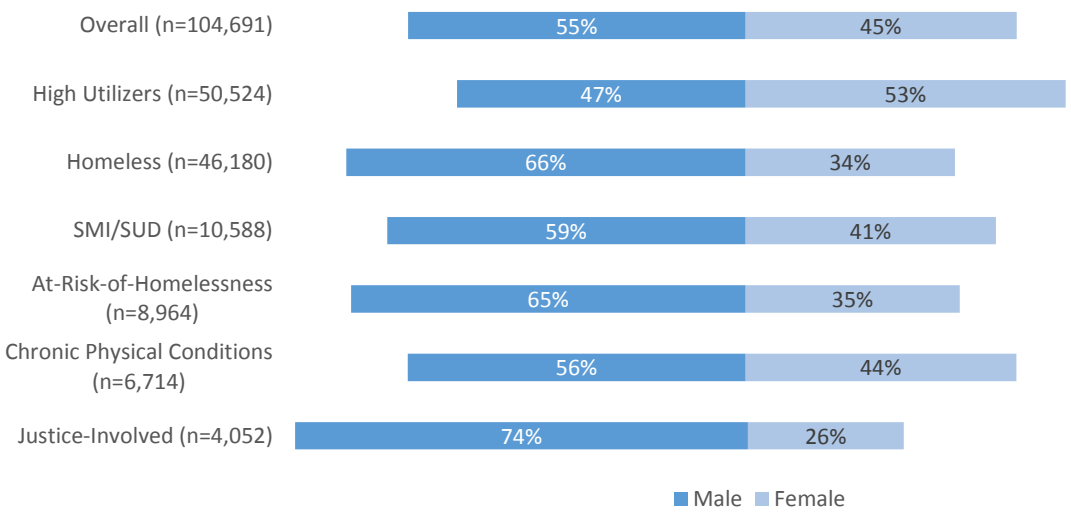
Exhibit 106: WPC Enrollee Age Overall and by Target Population, Based on First Month Prior to WPC Enrollment



Source: Medi-Cal enrollment data from January 2015 to December 2018 for 104,691 WPC enrollees identified in the quarterly *Whole Person Care Enrollment and Utilization Reports* from PY 2 – PY 3.
Notes: Includes 104,691 individuals identified as enrolled during PY 2 or PY 3 and with sufficient Medi-Cal enrollment data. Percentages for the 0-17 years of age group are not shown due to small numbers. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Most WPC enrollees were male (55%), including nearly all target populations (Exhibit 107). The only target population that was majority female (53%) was high utilizers.

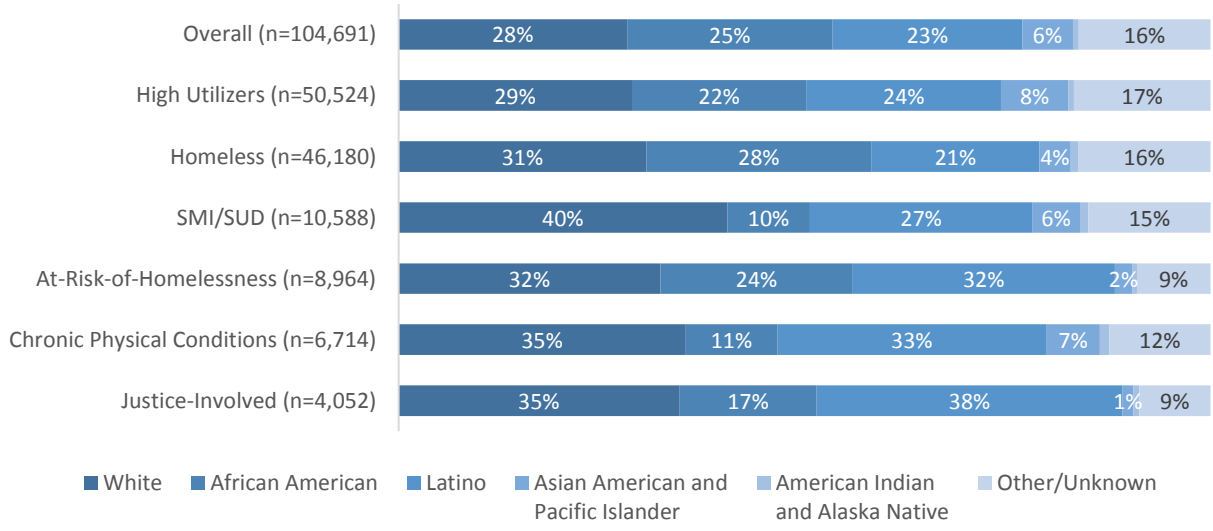
Exhibit 107: WPC Enrollee Gender by Target Population



Source: Medi-Cal enrollment data from January 2015 to December 2018 for 104,691 WPC enrollees identified in the quarterly *Whole Person Care Enrollment and Utilization Reports* from PY 2 – PY 3.
Notes: Includes 104,691 individuals identified as enrolled during PY 2 or PY 3 and with sufficient Medi-Cal enrollment and claims data. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

WPC enrollees were primarily White (28%), African American (25%), and Latino (23%), but this distribution varied by target population (Exhibit 108). For example, the justice-involved were most frequently Latino (38%) and those with SMI/SUD were most often white (40%).

Exhibit 108: WPC Enrollee Race/Ethnicity by Target Population

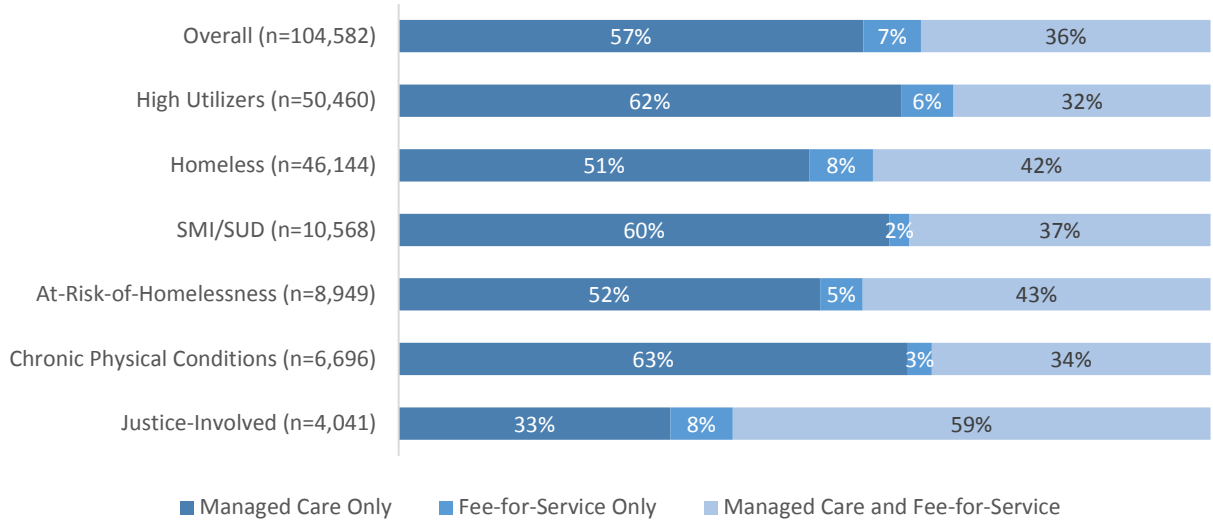


Source: Medi-Cal enrollment data from January 2015 to December 2018 for 104,691 WPC enrollees identified in the quarterly *Whole Person Care Enrollment and Utilization Reports* from PY 2 – PY 3.
Notes: Percentages for the American Indian and Alaska Native group were not shown due to small numbers. Includes 104,691 individuals identified as enrolled during PY 2 or PY 3 and with sufficient Medi-Cal enrollment data. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

The most common primary language of all WPC enrollees was English (87%), followed by Spanish (9%, data not shown). Enrollees in the justice-involved target population had the lowest percentage of non-English speakers (2-3%), while the high utilizer target population had the highest (18%, data not shown).

Prior to the start of WPC enrollment, most WPC enrollees were enrolled in only managed care (MC) plans (57%), while 7% received care only under Medi-Cal fee-for-service (FFS; Exhibit 109). Many WPC enrollees were enrolled in FFS for some time prior to MC enrollment or were receiving FFS services while being enrolled in MC plans (36%). Justice-involved enrollees were most often in this situation (59%) compared to other target populations. Enrollees with chronic physical conditions most often received care from MC plans only (63%).

Exhibit 109: WPC Enrollee Managed Care Enrollment by Target Population Before WPC Enrollment, January 2015 to December 2016

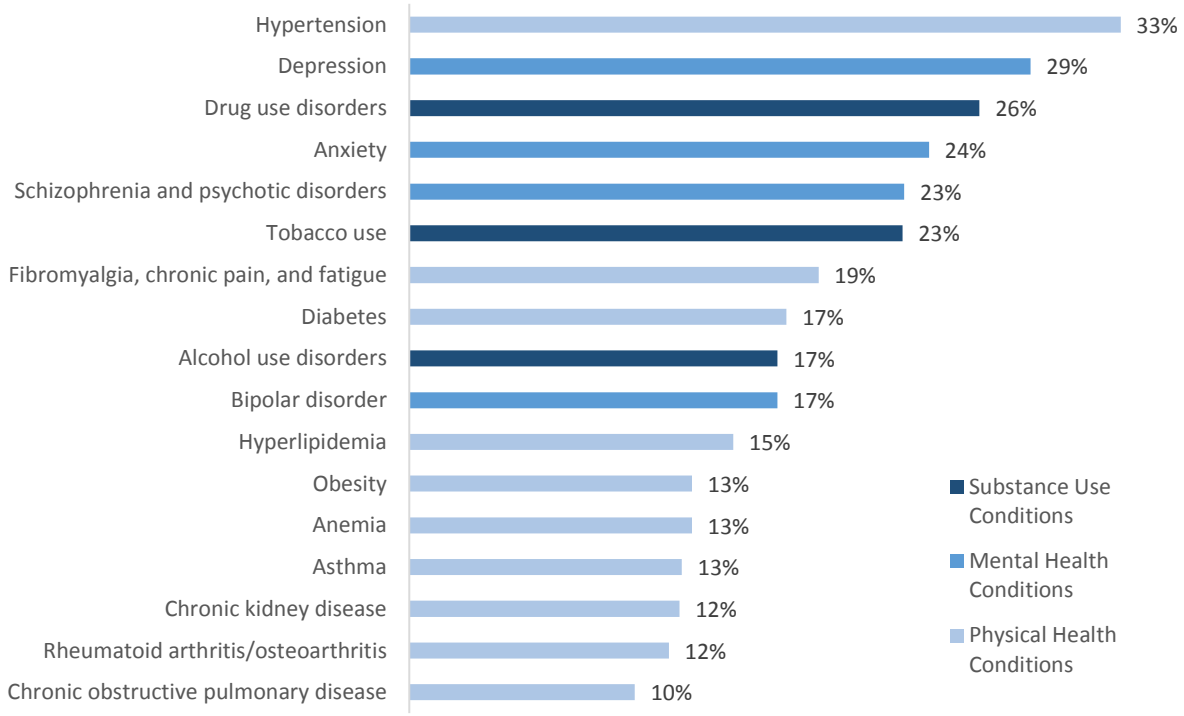


Source: Medi-Cal enrollment data from January 2015 to December 2016 for 104,691 WPC enrollees identified in the quarterly *Whole Person Care Enrollment and Utilization Reports* from PY 2 – PY 3.
Notes: Includes 104,582 individuals identified as enrolled during PY 2 or PY 3 and with sufficient Medi-Cal enrollment data. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Health Status

Among all WPC enrollees, 33% had hypertension, 29% had depression and 26% had a drug use disorder (Exhibit 110). Other common conditions included anxiety (24%), schizophrenia and psychotic disorders (23%) and tobacco use (23%).

Exhibit 110: Most Frequent Chronic or Disabling Conditions Among WPC Enrollees Prior to WPC Enrollment, January 2016 to December 2016



Source: Medi-Cal enrollment, claims and encounter data from January 2015 to December 2016 for 96,868 WPC enrollees identified in the quarterly *Whole Person Care Enrollment and Utilization Reports* from PY 2 – PY 3.
Notes: Chronic and disabling conditions were determined using algorithms developed by the CMS Chronic Conditions Data Warehouse (CCW). Conditions with at least 10% prevalence were displayed.

Chronic conditions varied by target population (Exhibit 111). Depression, anxiety and drug use disorders were common among all target populations (more than 20%). Drug use disorders were most common among enrollees with severe mental illness and/or substance use disorders (36%), the homeless (37%) and the justice-involved (36%). Schizophrenia and psychotic disorders were most common among enrollees with severe mental illness and/or substance use disorders (28%) and the homeless (26%). The justice-involved, the target population with the largest portion of younger enrollees, did not meet the 10% prevalence threshold of many of the chronic physical health conditions that were common in the other target populations.

Exhibit 111: WPC Enrollee Common Chronic or Disabling Conditions by Target Population Prior to WPC Enrollment, January 2016 to December 2016

Chronic or Disabling Condition	High Utilizers	Chronic Physical Conditions	SMI/ SUD	Homeless	At-Risk-of-Homelessness	Justice-Involved
Total	**43,076**	**5,615**	**8,822**	**35,534**	**6,638**	**2,495**
Substance Use Conditions						
Drug use disorders	22%	28%	36%	37%	29%	36%
Tobacco use	19%	25%	30%	31%	25%	30%
Alcohol use disorders	14%	18%	25%	23%	20%	17%
Mental Health Conditions						
Depression	25%	32%	36%	33%	34%	21%
Anxiety	23%	28%	34%	28%	27%	22%
Schizophrenia and psychotic disorders	16%	20%	28%	26%	25%	21%
Bipolar disorder	13%	22%	25%	21%	21%	17%
Physical Health Conditions						
Hypertension	34%	42%	37%	32%	29%	17%
Fibromyalgia, chronic pain, and fatigue	21%	25%	24%	19%	17%	13%
Diabetes	19%	26%	19%	15%	15%	---
Hyperlipidemia	15%	21%	19%	13%	15%	---
Obesity	12%	18%	14%	12%	14%	---
Anemia	13%	15%	14%	13%	11%	---
Asthma	13%	15%	14%	13%	11%	---
Chronic kidney disease	14%	21%	14%	12%	---	---
Rheumatoid arthritis/osteoarthritis	12%	16%	15%	13%	13%	---
Chronic obstructive pulmonary disease	---	15%	14%	12%	11%	---

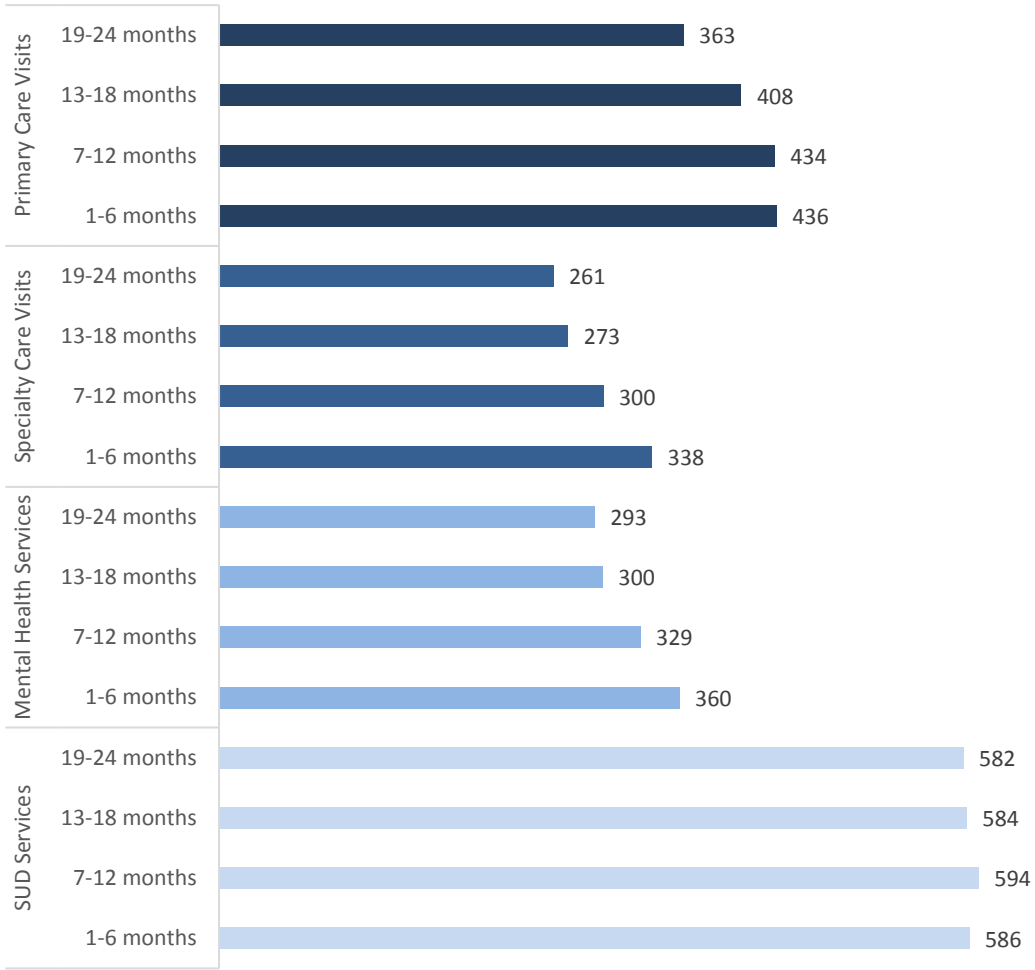
Source: Medi-Cal enrollment, claims and encounter data from January 2015 to December 2016 for 96,868 WPC enrollees identified in the quarterly *Whole Person Care Enrollment and Utilization Reports* from PY 2 – PY 3.
Notes: Chronic and disabling conditions were determined using algorithms developed by the CMS Chronic Conditions Data Warehouse (CCW). Patients with these conditions were identified based on the primary and secondary diagnosis in each encounter and claim. Only conditions with over 10% prevalence among WPC enrollees were included. Includes 96,868 individuals identified as enrolled during PY 2 or PY 3 and with sufficient Medi-Cal enrollment and claims data in the baseline period. Enrollees may be reported in more than one target population. SMI/SUD is severe mental illness and/or substance use disorder.

Utilization Prior to Enrollment

Ambulatory Care Prior to Enrollment

Medi-Cal claims data indicated WPC enrollees had 436 primary care visits per 1,000 Medi-Cal member months in the six months prior to their WPC enrollment, which had increased from 363 over the 24 months prior to WPC enrollment (Exhibit 112). Specialty visit and mental health service rates were lower than primary care in the six months prior to WPC enrollment but they also increased over time. Substance use disorder services rate remained stable in this time period.

Exhibit 112: Semi-Annual Ambulatory Care Visits and Services per 1,000 Medi-Cal Months During the 24 Months Prior to WPC Enrollment for PY 2 and PY 3 WPC Enrollees

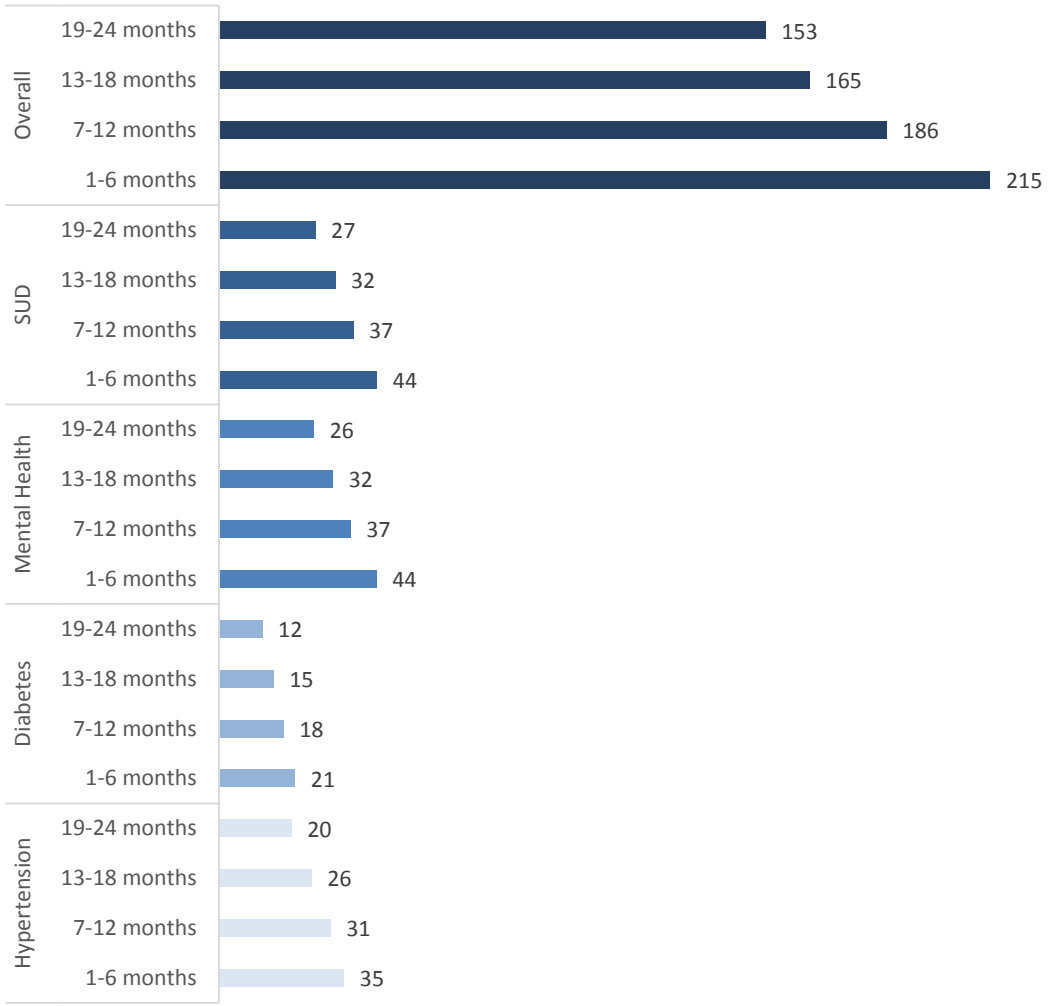


Source: Medi-Cal enrollment and claims data from 2015 to 2018 for 96,868 WPC enrollees identified in quarterly *Whole Person Care Enrollment and Utilization Reports,* PY 2 – PY 3.
Notes: Time period of months before WPC enrollment depends on individual enrollees' data of enrollment. SUD is Substance Use Disorders.

Emergency Department Visits Prior to Enrollment

Medi-Cal claims data showed that the rate of overall ED visits per 1,000 Medi-Cal member months increased over the 24 months before WPC enrollment, reaching 215 in the six months prior to enrollment (Exhibit 113). Examining ED visit rates by diagnosis showed increasing rates over the 24 months before WPC enrollment for all diagnosis types. ED visits with a primary or secondary diagnosis of SUD or a mental health condition were most common at 44 visits per 1,000 Medi-Cal member months in the six months prior to WPC enrollment, while diabetes- and hypertension-related ED visit rates in the same time period were 21 and 35, respectively.

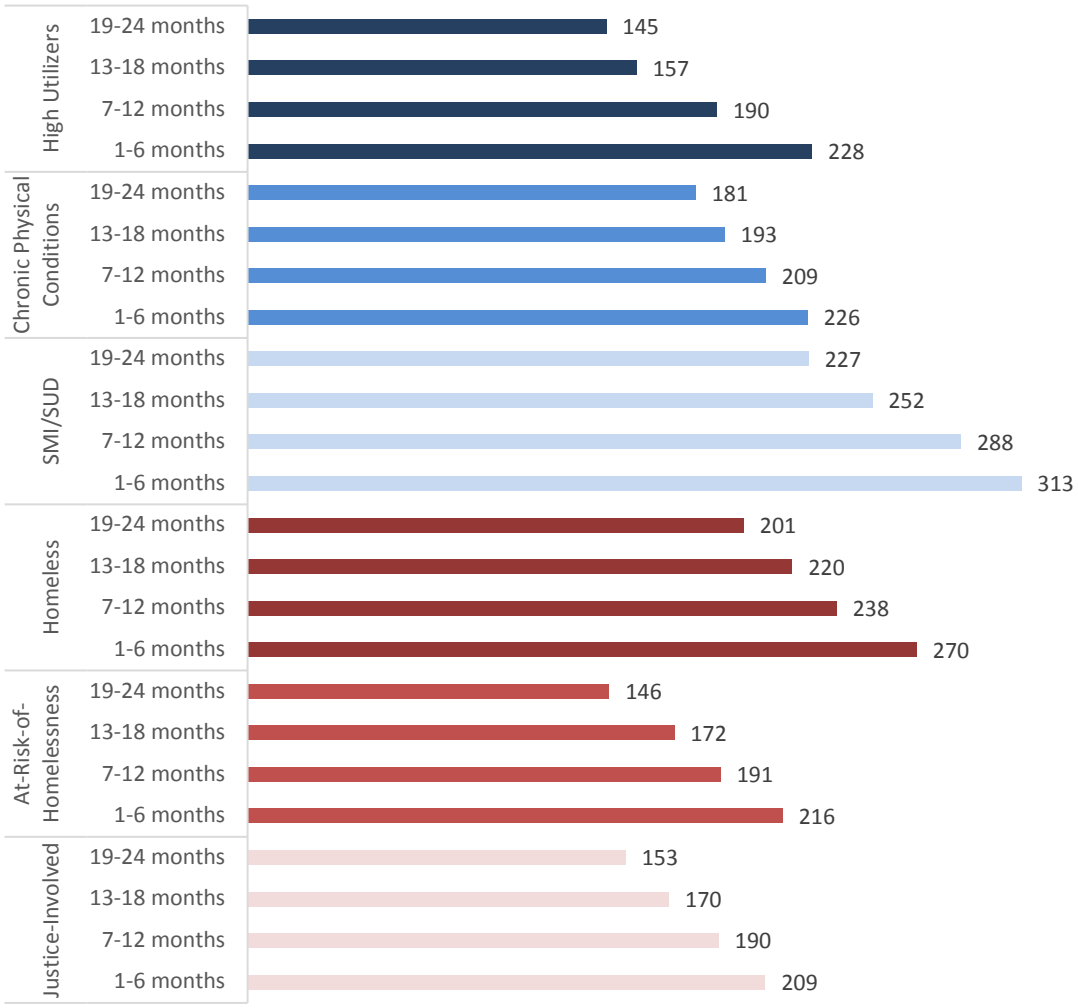
Exhibit 113: Semi-Annual Emergency Department Visits Followed by Discharge per 1,000 Medi-Cal Member Months During the 24 Months Prior to WPC Enrollment for PY 2 and PY 3 WPC Enrollees, Overall and by Diagnosis



Source: Medi-Cal enrollment and claims data from 2015 to 2018 for 96,868 WPC enrollees identified in the 25 *Whole Person Care Enrollment and Utilization Reports*.
Notes: Time period of months before WPC enrollment depends on individual enrollees' data of enrollment. SUD is Substance Use Disorders.

The rate of ED visits by target population showed an increase for all target populations over the 24 months before enrollment, and these rates were higher for enrollees identified in the SMI/SUD and homeless target populations in the year prior to WPC enrollment (Exhibit 114). The rates also increased more for enrollees in the high utilizer and at-risk-of-homelessness target populations over time.

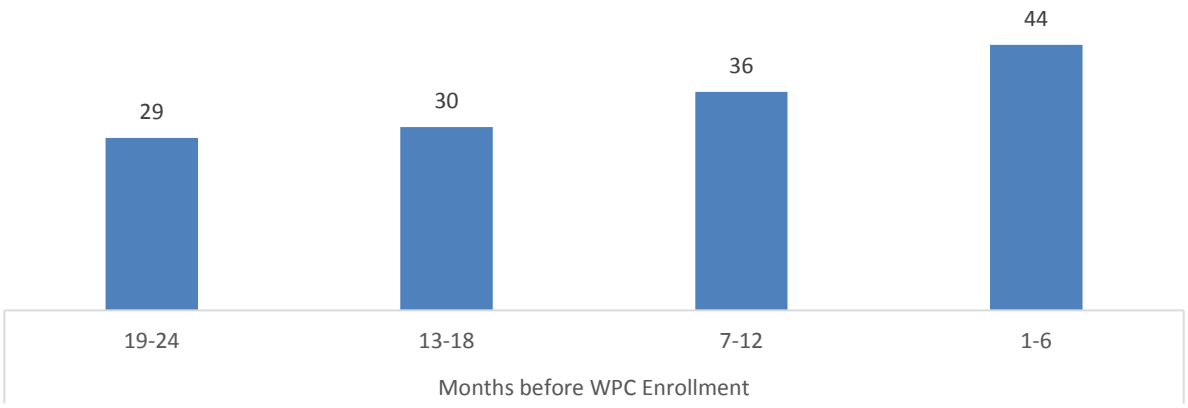
Exhibit 114: Semi-Annual Emergency Department Followed by Discharge Visits per 1,000 Medi-Cal Months During the 24 Months Prior to WPC Enrollment for PY 2 and PY 3 WPC Enrollees, by Target Population



Source: Medi-Cal enrollment and claims data from 2015 to 2018 for 96,868 WPC enrollees identified in quarterly *Whole Person Care Enrollment and Utilization Reports,* PY 2 – PY 3.
Notes: Time period of months before WPC enrollment depends on individual enrollees' data of enrollment. Enrollees can be in more than one target population. SMI/SUD is severe mental illness and/or substance use disorders.

Examining rates of ED visits followed by hospitalizations also showed a similar increase over time to that observed for ED visits followed by discharge (Exhibit 115). The overall rate in the six months prior to enrollment was 44 ED visits followed by hospitalization per 1,000 Medi-Cal member months.

Exhibit 115: Semi-Annual Emergency Department Visits Followed by Hospitalization per 1,000 Medi-Cal Member Months During the 24 Months Prior to WPC Enrollment for PY 2 and PY 3 WPC Enrollees

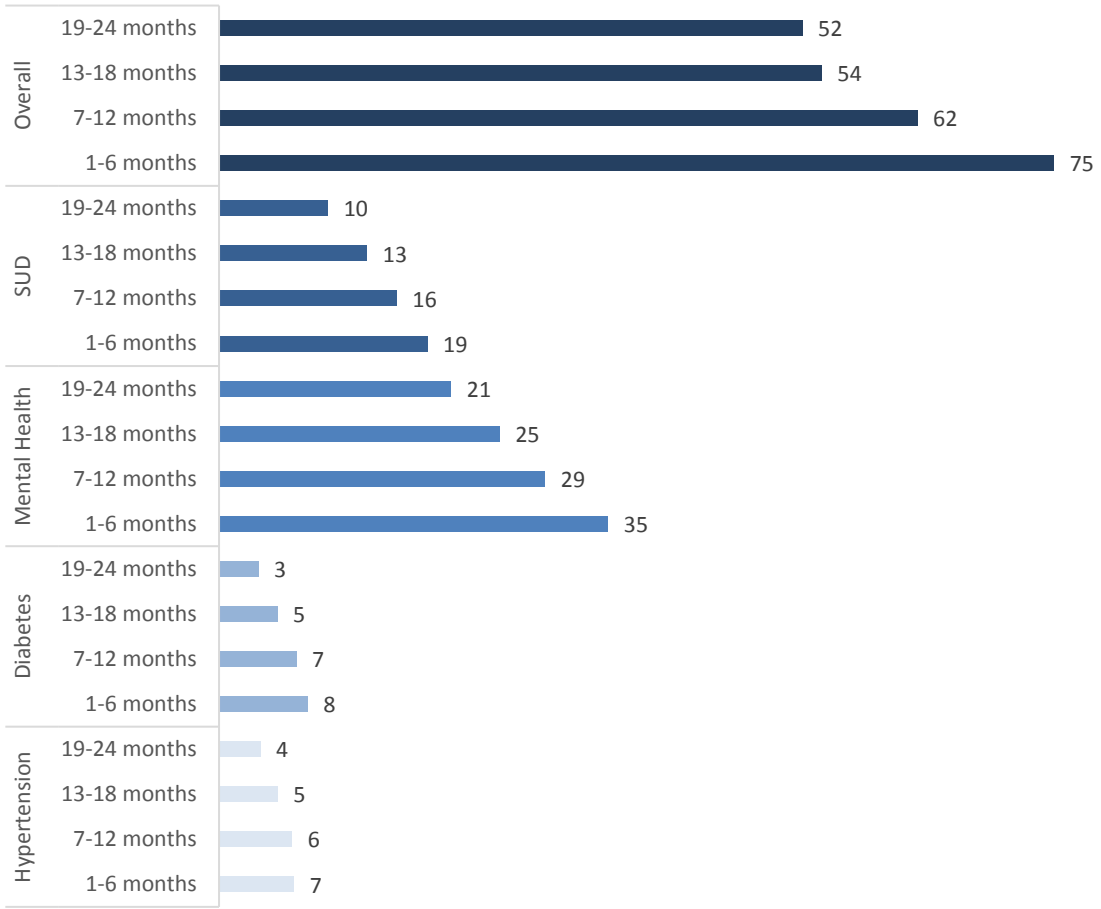


Source: Medi-Cal enrollment and claims data from 2015 to 2018 for 96,868 WPC enrollees identified in quarterly *Whole Person Care Enrollment and Utilization Reports,* PY 2 – PY 3.
Notes: Time period of months before WPC enrollment depends on individual enrollees' data of enrollment.

Hospitalization Prior to Enrollment

Medi-Cal claims data indicated WPC enrollees had 75 hospitalizations per 1,000 Medi-Cal member months in the six months prior to their WPC enrollment, which had increased from 52 over the 24 months prior to WPC enrollment (Exhibit 116). Hospitalizations with primary or secondary diagnoses of a substance use disorder, mental health condition, diabetes, and hypertension also increased over the 24 months prior to WPC enrollment, with hospitalization rates for mental health conditions and substance use disorder highest at 35 and 19 six months before WPC enrollment, respectively.

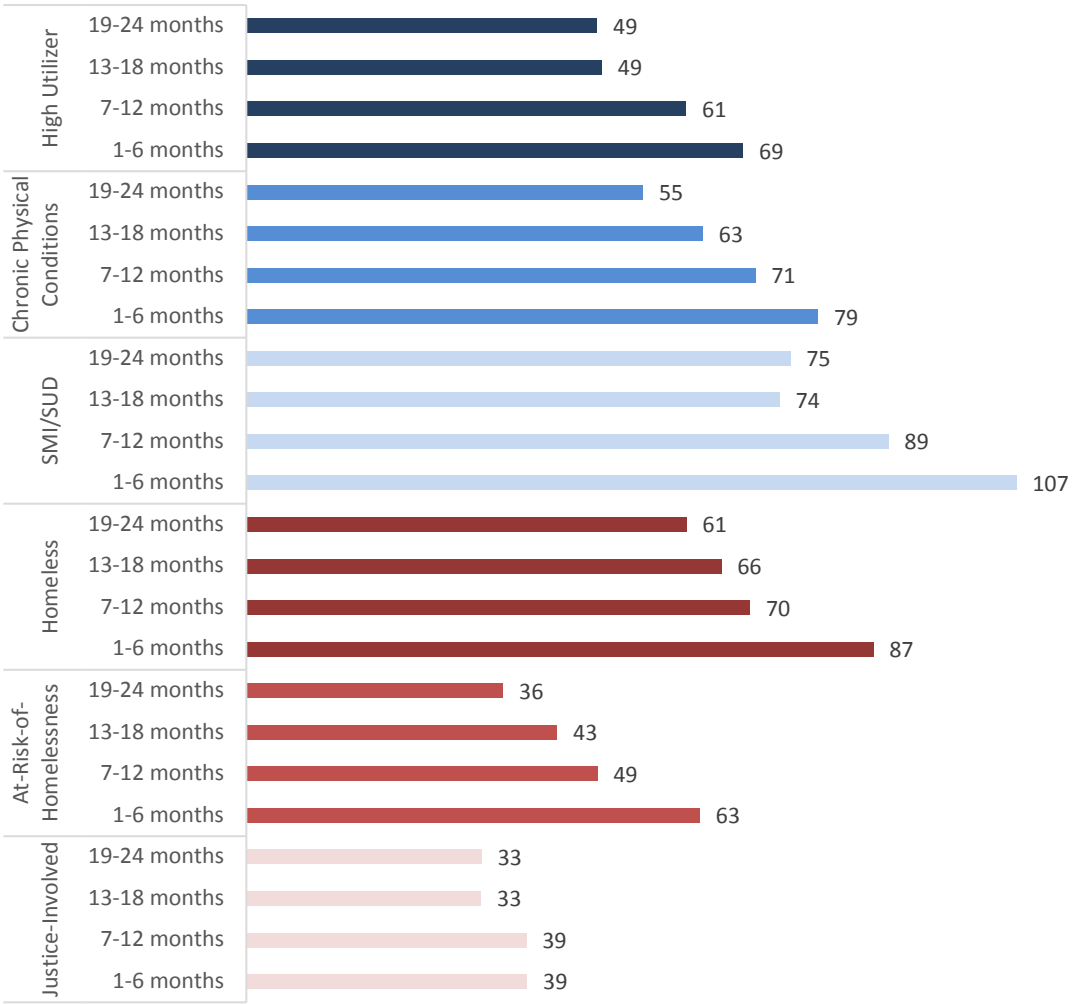
Exhibit 116: Semi-Annual Number of Hospitalization per 1,000 Medi-Cal Member Months During the 24 Months Prior to WPC Enrollment for PY 2 and PY 3 WPC Enrollees, Overall and by Diagnosis



Source: Medi-Cal enrollment and claims data from 2015 and PY 1 for 96,868 WPC enrollees identified in the 25 *Whole Person Care Enrollment and Utilization Reports*.
Notes: Time period of months before WPC enrollment depends on individual enrollees' data of enrollment. SUD is Substance Use Disorders.

The rate of hospitalizations by target population showed an increase for all target populations over the 24 months before enrollment, and these rates were higher for enrollees identified in the SMI/SUD and homeless target populations in the year prior to WPC enrollment (Exhibit 117). The rates also increased more for enrollees in the high utilizer and at-risk-of-homelessness target populations over time.

Exhibit 117: Semi-Annual Number of Hospitalizations per 1,000 Medi-Cal Months During the 24 Months Prior to WPC Enrollment for PY 2 and PY 3 WPC Enrollees, by Target Population



Source: Medi-Cal enrollment and claims data from 2015 to 2018 for 96,868 WPC enrollees identified in quarterly *Whole Person Care Enrollment and Utilization Reports,* PY 2 – PY 3.
Notes: Time period of months before WPC enrollment depends on individual enrollees' data of enrollment. Enrollees can be in more than one target population. SMI/SUD is severe mental illness and/or substance use disorders.

Chapter 11: Better Care

WPC Pilots aimed to increase "appropriate access to care for the most vulnerable Medi-Cal beneficiaries." This chapter addresses the following evaluation question: "To what extent did the Pilots increase appropriate access to care and improve beneficiary care outcomes?" Data sources for this chapter included *WPC Enrollment and Utilization Reports* from PY 2 – PY 3 *and* Medi-Cal enrollment and claims that were used to create two universal metrics (2.3 - Follow-Up After Hospitalization for Mental Illness and 2.4 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment). The *Annual WPC Variant and Universal Metric Reports* submitted by Pilots to DHCS at the end of PY 2, and PY 3 were used to report on one universal (2.5 - Comprehensive Care Plan) and one variant (3.1.7 - Major Depressive Disorder Suicide Risk Assessment) metric that could not be created using Medi-Cal enrollment and claims data. Pilot-reported metrics on follow-up after hospitalization for mental illness and initiation and engagement of alcohol and other drug dependence treatment were not reported because they were found to be heavily dependent on data sharing agreements and data sharing capacity during the first three years of WPC and were therefore incomplete. The remaining Pilot-reported metrics could not be created using Medi-Cal data. These data were often based on electronic medical records or chart review and were considered complete and reliable. For additional detail on data sources and methodology please see the Analytic Methods and Appendices A and B.

Unadjusted Trends in WPC Metrics Using Medi-Cal Data, Before and After WPC Enrollment

UCLA used Medi-Cal data to replicate better care metrics following DHCS specifications, when possible. Only two universal metrics, 2.3 (follow-up after hospitalization for mental illness) and 2.4 (initiation and engagement of AOD dependence treatment), could be calculated (Exhibit 118).

For these analyses, UCLA identified pre- and post-WPC enrollment years for each WPC enrollee based on their individual date of first enrollment into WPC. Therefore, baseline periods reflected two years before (Pre-WPC Year 2) and one year before WPC enrollment (Pre-WPC Year 1). The enrollment period included one year after (WPC Year 1) and two years after WPC enrollment (WPC Year 2). All measurement years were based on Medi-Cal enrollment and not WPC enrollment.

Ultimately, 96,868 enrollees with sufficient Medi-Cal data in both the baseline and enrollment time periods were used for these analyses, but the denominator was further reduced based on DHCS metric specification. For additional details on data sources and methodology, please see Appendix A, and for a complete list of metrics by Pilot and target populations, please see Appendix I.

Exhibit 118: Universal and Variant Metrics That Indicate Better Care Using Medi-Cal Data

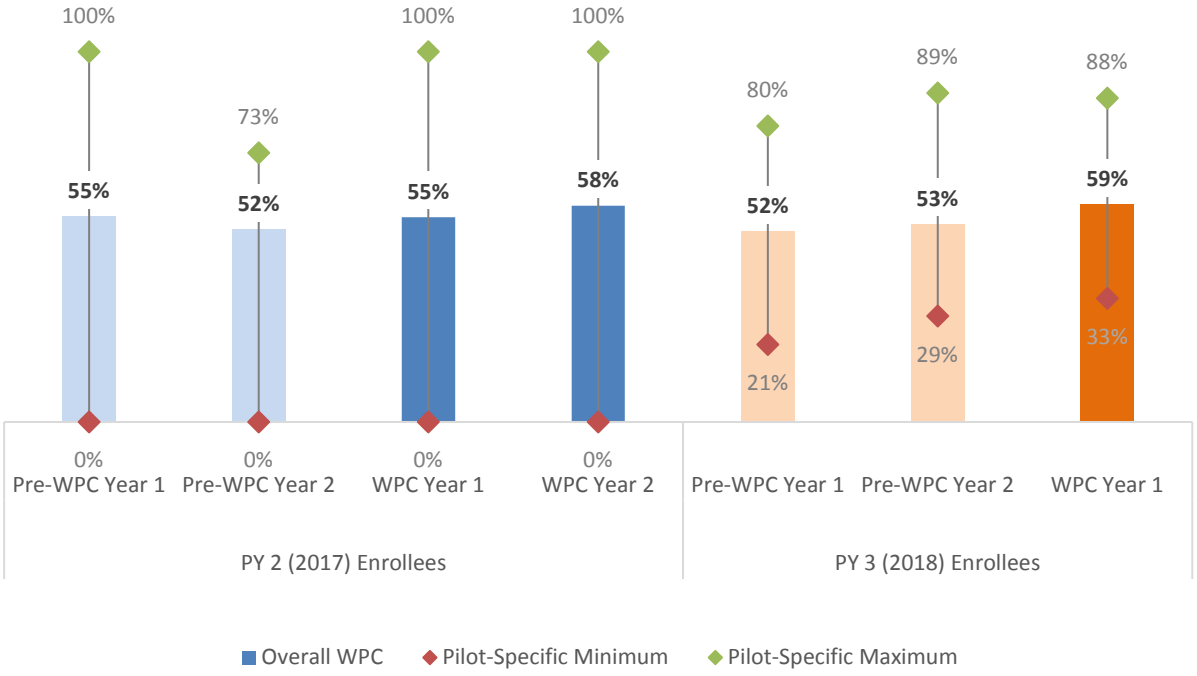
Universal vs. Variant	Metric Name and Number	Description	Improvement Measured by Increase or Decrease
Universal	2.3: Follow-Up After Hospitalization for Mental Illness (FUH)	FUH-7: Percent of discharges for which the enrollee received follow-up within seven days of discharge	Increase
		FUH-30: Percent of discharges for which the enrollee received follow-up within 30 days of discharge	Increase
Universal	2.4: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	IET-14: Percentage of enrollees who initiated treatment through an inpatient alcohol and other drugs (AOD) admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis	Increase
		IET-30: Percentage of beneficiaries who initiated treatment and who had two or more	Increase

Universal vs. Variant	Metric Name and Number	Description	Improvement Measured by Increase or Decrease
		additional services with a diagnosis of AOD within 30 days of the initiation visit	

Universal Metric 2.3: Follow-Up After Hospitalization for Mental Illness

All WPC Pilots were required to report on FUH-7 and FUH-30 and UCLA recreated these metrics using Medi-Cal claims data. For FUH-7, the rate for PY 2 enrollees was lower in Pre-WPC Year 2 (52%) and increased in WPC Years 1 and 2 (55% and 58%, Exhibit 119). A similar increase from Pre-WPC Year 2 to WPC Year 1 was seen for PY 3 enrollees (53% to 59%). The variability by Pilot was large, ranging between 0% and 100% for nearly every measurement year among PY 2 enrollees, which was largely due to some Pilots having very low enrollment numbers during PY 2. Less variability was seen among Pilots for PY 3 enrollees.

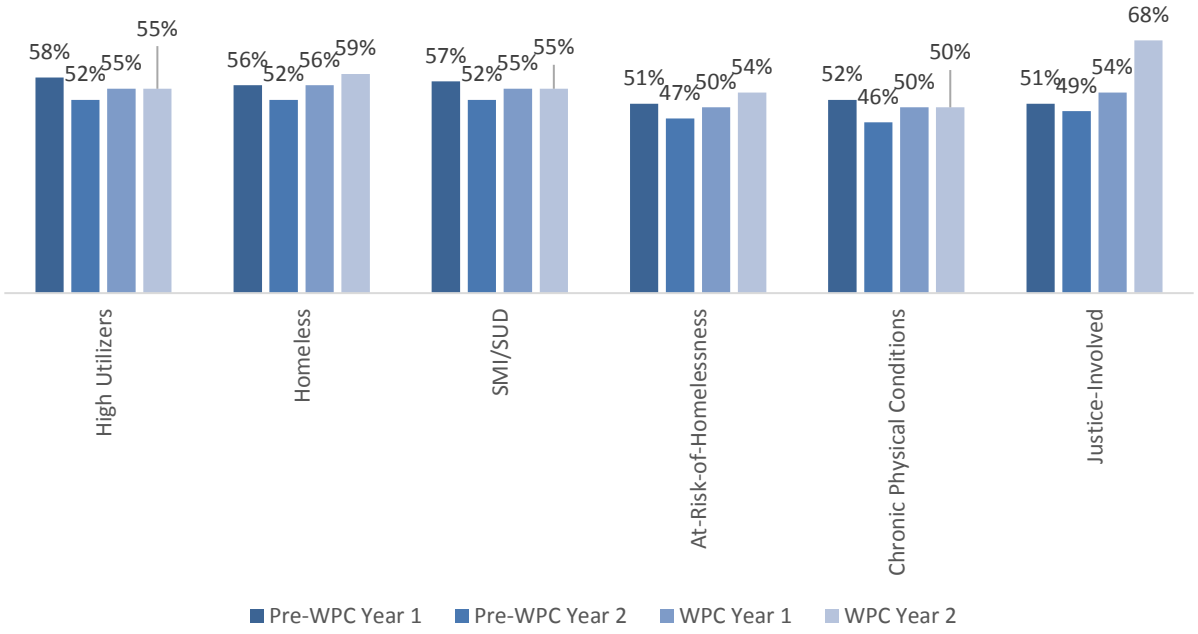
Exhibit 119: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 7 days (FUH-7) for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated no follow-up in the allotted timeframe during the measurement year.

When examining rates by PY 2 enrollee target populations, FUH-7 trends were consistent across groups (Exhibit 120). The lowest rates were observed in Pre-WPC Year 2 and increased during WPC Year 1 and 2. Among PY 2 enrollees identified as justice-involved, rates increased more dramatically increased from WPC Year 1 to WPC Year 2 (54% to 68%). Among PY 2 enrollees identified as high utilizers, SMI/SUD, and having chronic physical conditions, the FUH-7 rate in WPC Year 2 was still below Pre-WPC Year 1 rates.

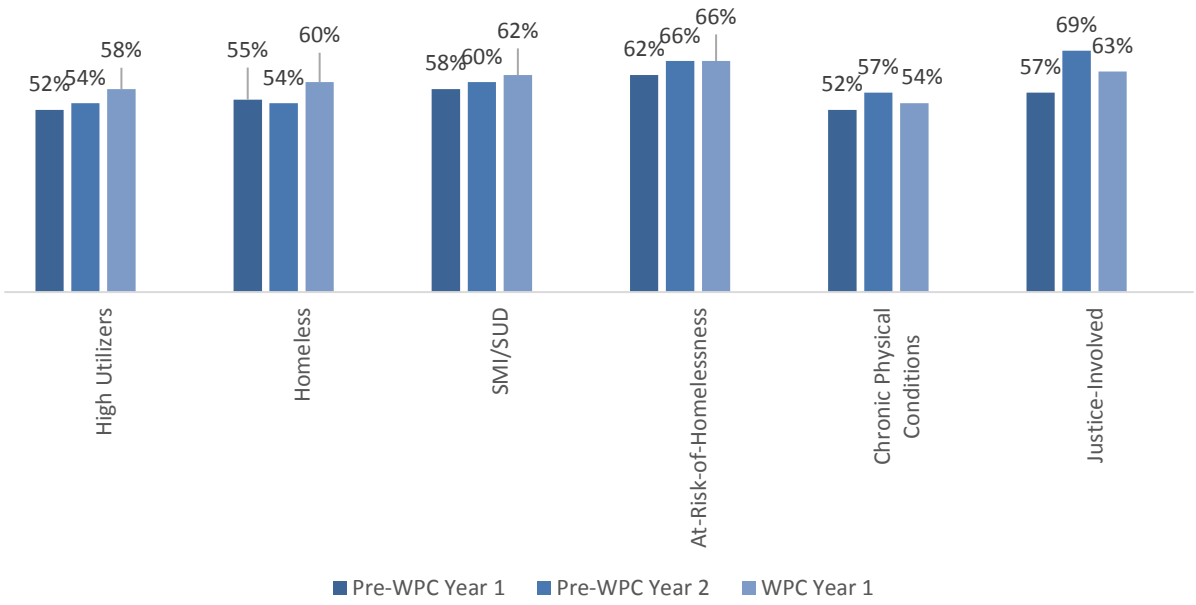
Exhibit 120: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 7 days (FUH-7) for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated no follow-up in the allotted timeframe during the measurement year. Enrollees can be in more than one target population.

When examining FUH-7 trends by PY 3 enrollee target populations, rates increased from Pre-WPC Year 1 to WPC Year 1 among all target populations (Exhibit 121). Rates peaked during Pre-WPC Year 2 among enrollees identified as having chronic physical conditions and justice-involved, but remained above Pre-WPC Year 1 rates in WPC Year 1.

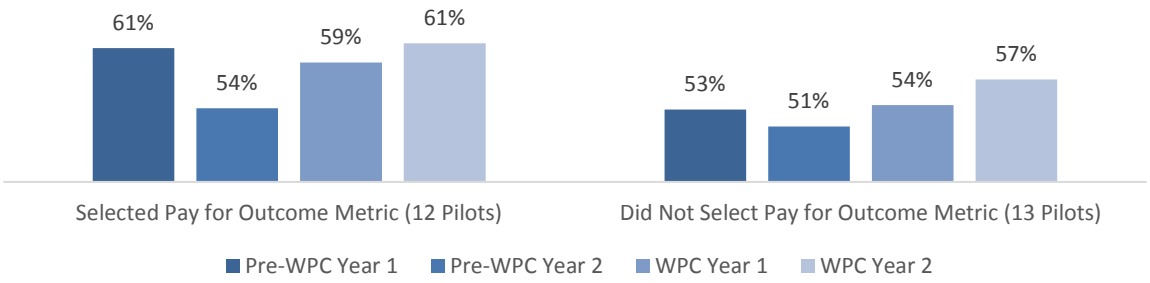
Exhibit 121: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 7 days (FUH-7) for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC Enrollees can be in more than one target population.

When examining rates of FUH-7 among PY 2 enrollees by whether the Pilots had a pay for outcome (P4O) for a similar performance measure, overall rates were higher and there was an increase from Pre-WPC Year 2 to WPC Year 2 (54% to 61%) among Pilots with a P4O (Exhibit 122). Among Pilots without a P4O, the rate during the same time increased from 51% to 57%.

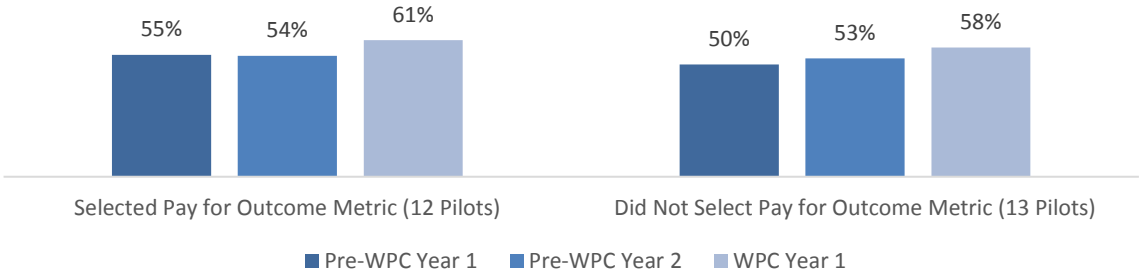
Exhibit 122: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 7 days (FUH-7) for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 14 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Among PY 3 enrollees, there was less of an impact due to P4O incentives (Exhibit 123). Pilots with and without P4O had similar FUH-7 rates and the increase after WPC enrollment was also similar.

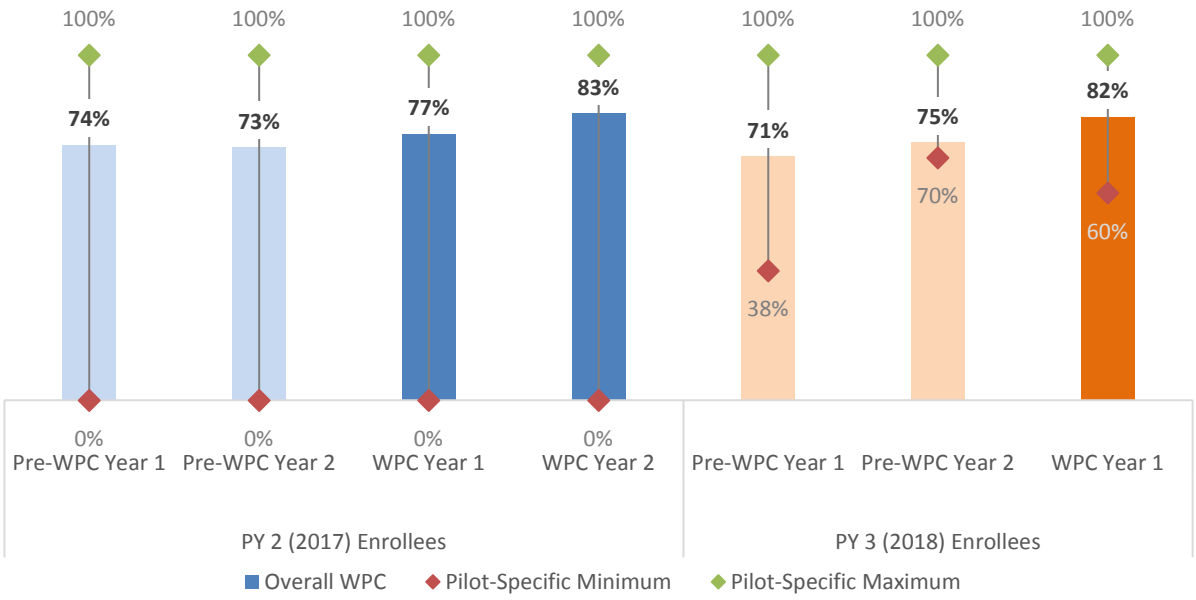
Exhibit 123: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 7 days (FUH-7) for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 14 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

For FUH-30, the rate for PY 2 enrollees was lower in Pre-WPC Year 2 (73%) and increased in WPC Years 1 and 2 (77% and 83%, Exhibit 124). A similar increase from Pre-WPC Year 2 to WPC Year 1 was seen for PY 3 enrollees (75% to 82%). The variability by Pilot was large, ranging between 0% and 100% for every measurement year among PY 2 enrollees, which was largely due to some Pilots having very low enrollment numbers during PY 2. Less variability was seen among Pilots for PY 3 enrollees.

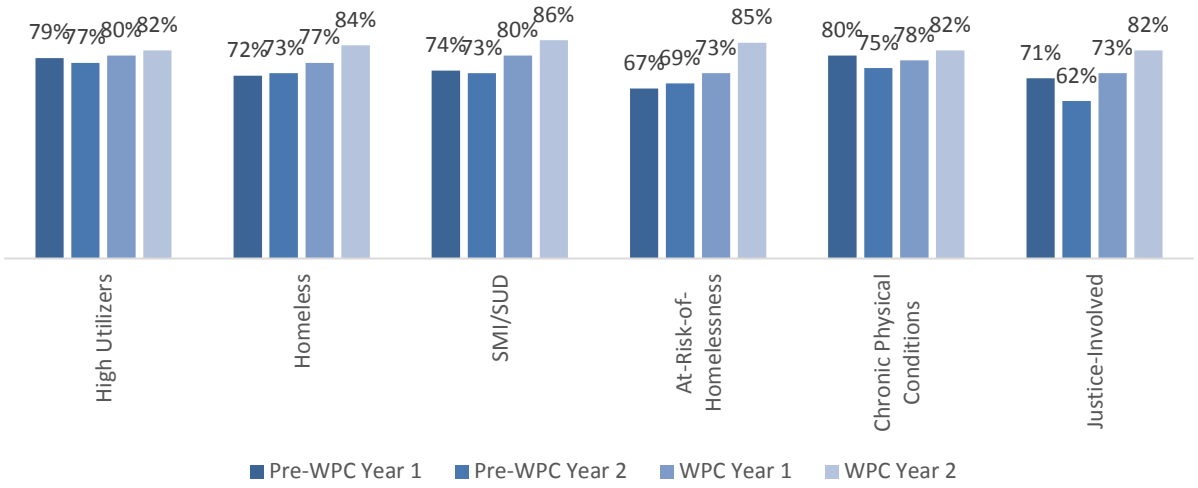
Exhibit 124: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 30 days (FUH-30) for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated no follow-up in the allotted timeframe during the measurement year.

When examining rates by PY 2 enrollee target populations, FUH-30 trends were consistent across groups (Exhibit 125). The lowest rates were in Pre-WPC Years and increased during WPC Years 1 and 2. Among PY 2 enrollees identified as justice-involved, rates increased more dramatically from Pre-WPC Year 2 to WPC Year 2 (62% to 82%).

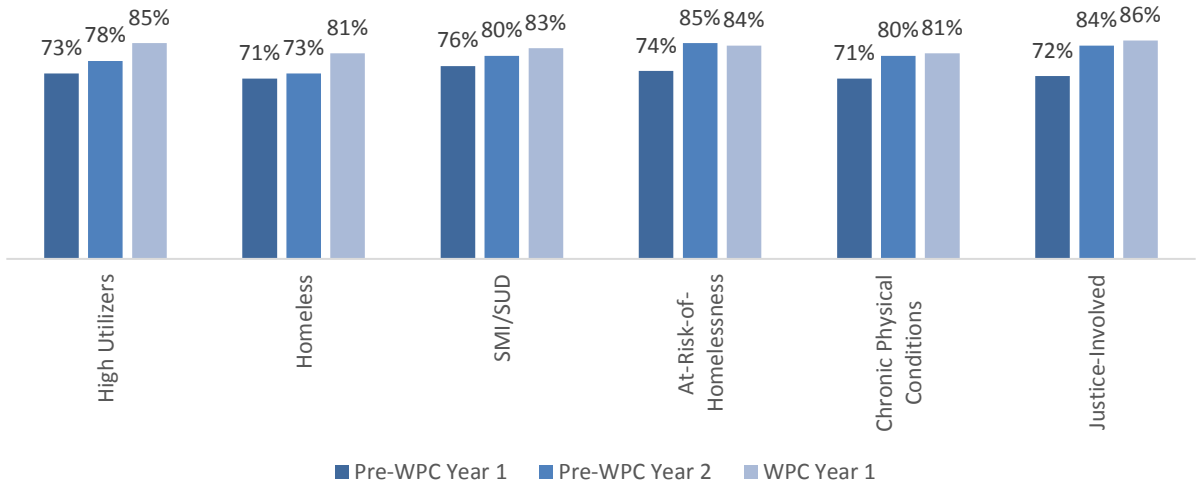
Exhibit 125: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 30 days (FUH-30) for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated no follow-up in the allotted timeframe during the measurement year. Enrollees can be in more than one target population.

When examining FUH-30 trends by PY 3 enrollee target populations, rates increased from Pre-WPC Year 1 to WPC Year 1 among all target populations except for enrollees identified as at-risk-of-homelessness (Exhibit 126). Among those identified as at-risk-of-homelessness, there was a slight decline in FUH-30 between Pre-WPC Year 2 and WPC Year 1, from 85% to 84%.

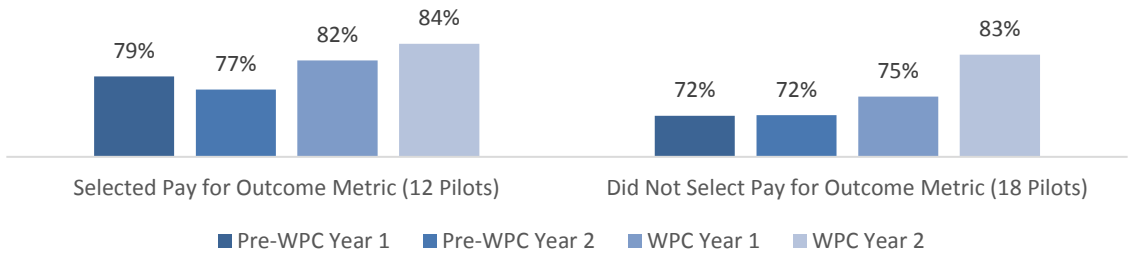
Exhibit 126: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 30 days (FUH-30) for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated no follow-up in the allotted timeframe during the measurement year. Enrollees can be in more than one target population.

When examining rates of FUH-30 among PY 2 enrollees by whether the Pilots had a P4O for a similar performance measure, there was little impact due to P4O incentives (Exhibit 127). Overall rates were slightly higher and there was an increase from Pre-WPC Year 2 to WPC Year 2 (77% to 84%) among Pilots with a P4O. Among Pilots without a P4O, the rates during the same time period increased from 72% to 83%.

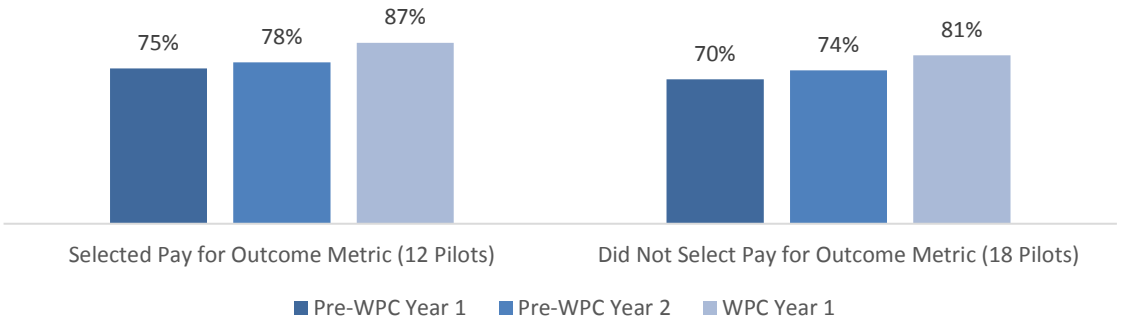
Exhibit 127: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 30 days (FUH-30) for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 14 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Among PY 3 enrollees, there almost no impact due to P4O incentives (Exhibit 128). Pilots with and without P4O had similar FUH-30 rates and the increase after WPC enrollment was similar.

Exhibit 128: Unadjusted Rates of Follow-Up After Hospitalization for Mental Illness at 30 days (FUH-30) for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



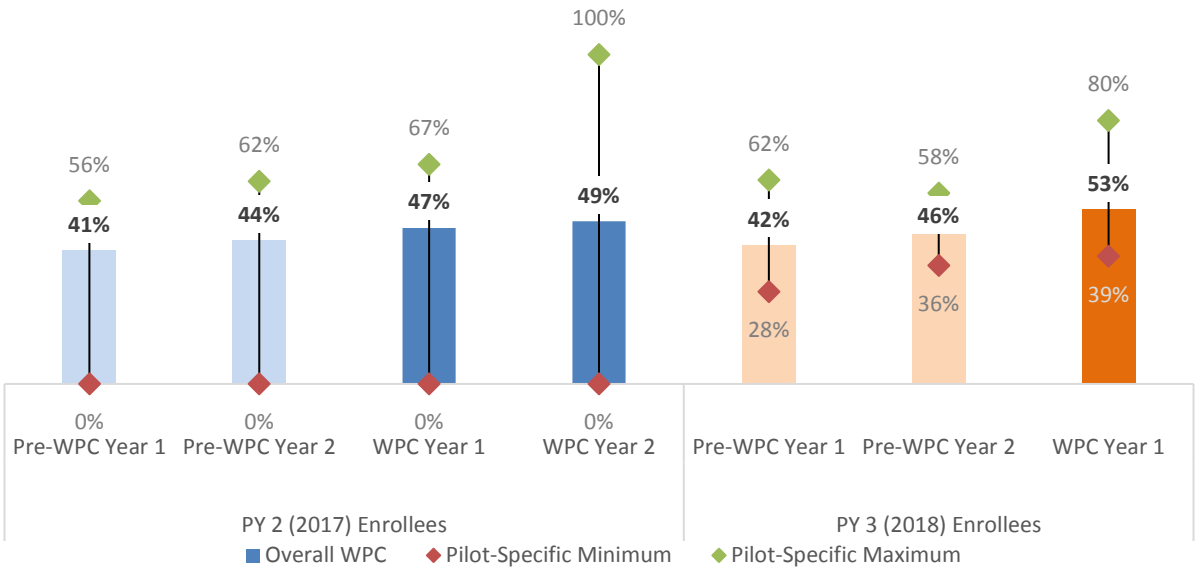
Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 22,189 WPC person-years with sufficient Medi-Cal enrollment and claims data and a hospitalization for mental illness. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 14 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Examining the FUH rates for all WPC enrollees after adjusting for enrollee and Pilot characteristics showed similar patterns of steady rates in the Pre-WPC Years and overall higher rates in the WPC Years (Appendix K, Exhibit 1). While the unadjusted rates increased from WPC Year 1 to WPC Year 2 for PY 2 enrollees, the adjusted rates among all enrollees showed a smaller increased or slight decline.

Universal Metric 2.4: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

All Pilots were required to report on IET-14 and IET-30 and UCLA recreated this metric using Medi-Cal data. The IET-14 rate for PY 2 and PY 3 enrollees was higher in both WPC Years compared to the Pre-WPC Years. Similarly, the maximum Pilot-specific rate was also higher in the WPC Years compared to the Pre-WPC Years. The variability by Pilot was large, ranging between 0% and 100% in WPC Year 2 among PY 2 enrollees, which was largely due to some Pilots having very low enrollment numbers during PY 2. Less variability was seen among Pilots for PY 3 enrollees.

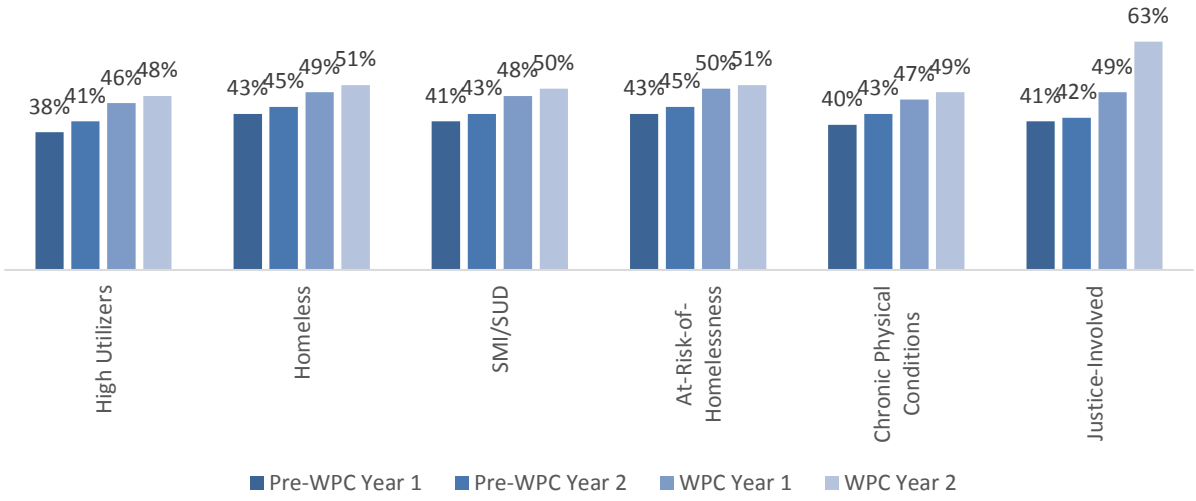
Exhibit 129: Trends in Initiation of Alcohol and Other Drug Dependence Treatment for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal claims and encounter data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated that no enrollees initiated or engaged in alcohol or other drug dependence treatment during the timeframe.

When examining IET-14 rates by PY 2 enrollee target populations, rates increased from Pre-WPC Year 1 to WPC Year 2 among all target populations (Exhibit 130). Among PY 2 enrollees identified as justice-involved, rates increased more dramatically from Pre-WPC Year 2 to WPC Year 2 (42% to 63%).

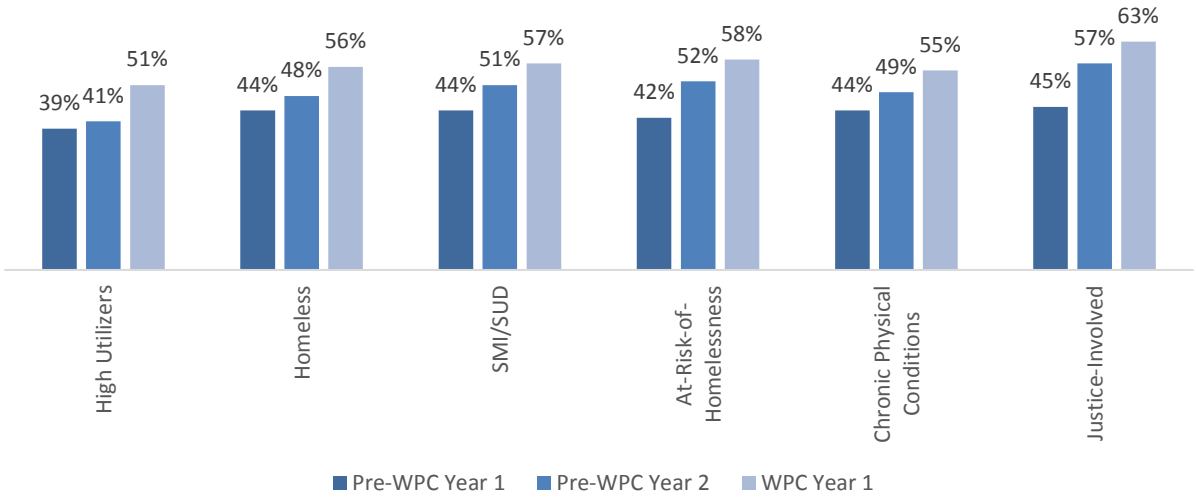
Exhibit 130: Unadjusted Rates of Initiation of Alcohol and Other Drug Dependence Treatment for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal claims and encounter data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

When examining IET-14 rates by PY 3 enrollee target populations, rates increased from Pre-WPC Year 1 to WPC Year 1 among all target populations (Exhibit 131). Among PY 3 enrollees identified as justice-involved, rates increased more dramatically from Pre-WPC Year 1 to WPC Year 1 (45% to 63%).

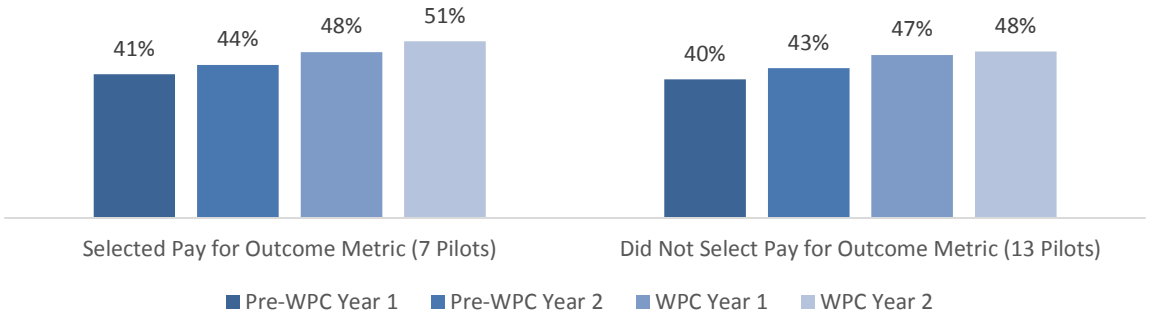
Exhibit 131: Unadjusted Rates of Initiation of Alcohol and Other Drug Dependence Treatment for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal claims and encounter data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

When examining IET-14 rates among PY 2 enrollees by whether Pilots had a P4O for a similar performance measure, there was little impact from P4O (Exhibit 132). Pilots with and without P4O showed increasing rates over time and similar overall rates.

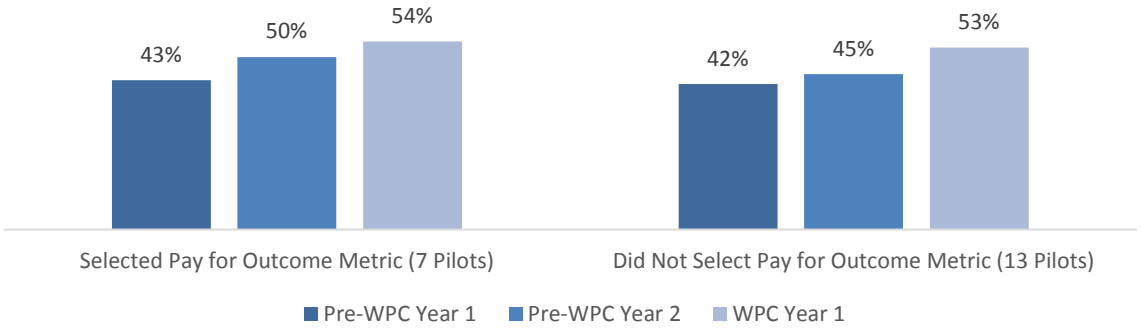
Exhibit 132: Unadjusted Rates of Initiation of Alcohol and Other Drug Dependence Treatment for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 15 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Among PY 3 enrollees, there was also no impact from P40 incentives (Exhibit 133).

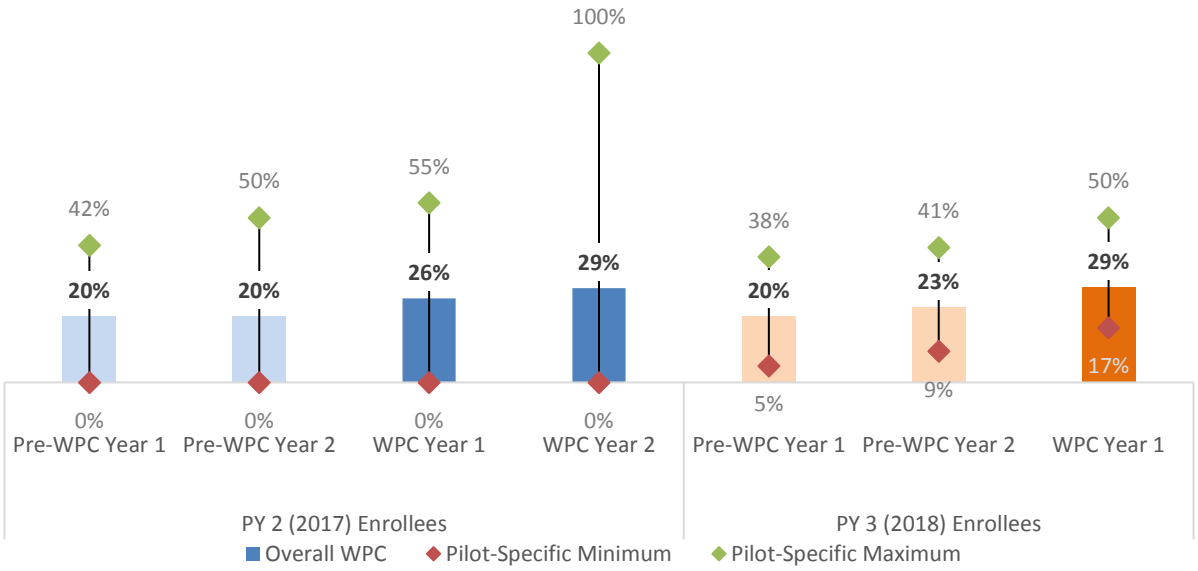
Exhibit 133: Unadjusted Rates of Initiation of Alcohol and Other Drug Dependence Treatment for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 15 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

The IET-30 rates for PY 2 and PY 3 enrollees were higher in WPC Years 1 and 2 compared to Pre-WPC Years 1 and 2 (Exhibit 134). The rate for PY 2 enrollees increased to 26% and 29% in WPC Years 1 and 2, respectively compared to 20% in the Pre-WPC Years. A similar increase from Pre-WPC 2 to WPC Year 1 was seen for PY 3 enrollees (23% to 29%). There was variability by Pilot, ranging from 0% to 100% in WPC Year 2 for PY 2 enrollees, which was largely due to some Pilots having very low enrollment numbers during PY 2.

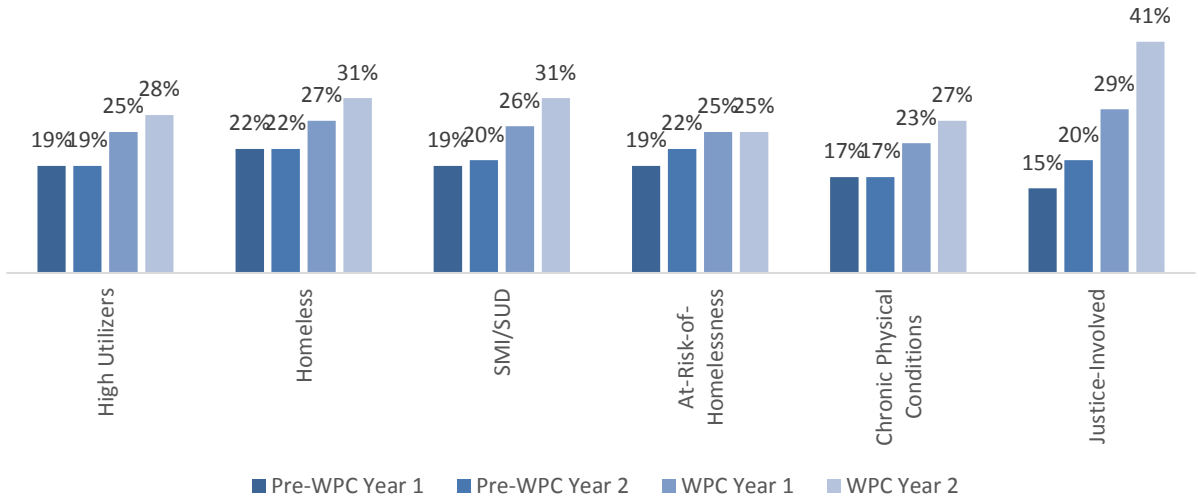
Exhibit 134: Trends in Engagement of Alcohol and Other Drug Dependence Treatment for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal claims and encounter data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. A rate of 0% indicated that no enrollees initiated or engaged in alcohol or other drug dependence treatment during the timeframe.

When examining IET-30 rates by PY 2 enrollee target populations, engagement increased among all target populations from Pre-WPC Year 1 to WPC Year 2 (Exhibit 135). Among PY 2 enrollees identified as justice-involved, rates increased more dramatically from Pre-WPC Year 1 to WPC Year 2 (15% to 41%).

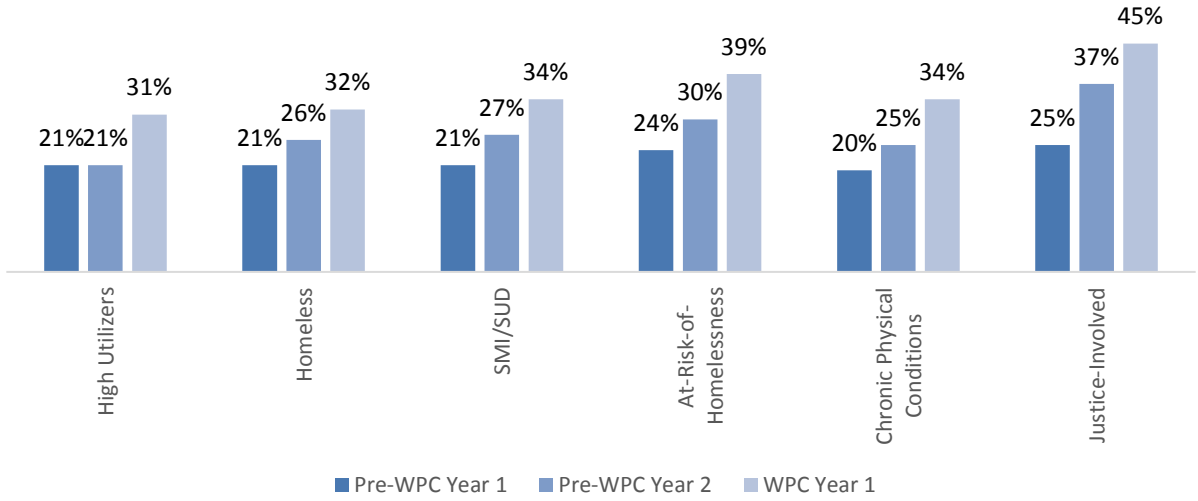
Exhibit 135: Unadjusted Rates of Engagement of Alcohol and Other Drug Dependence Treatment for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal claims and encounter data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

When examining rates by PY 3 enrollee target populations, engagement increased among all target populations from Pre-WPC Year 1 to WPC Year 1 (Exhibit 136). Among PY 3 enrollees identified as justice-involved, rates increased more dramatically from Pre-WPC Year 1 to WPC Year 1 (25% to 45%).

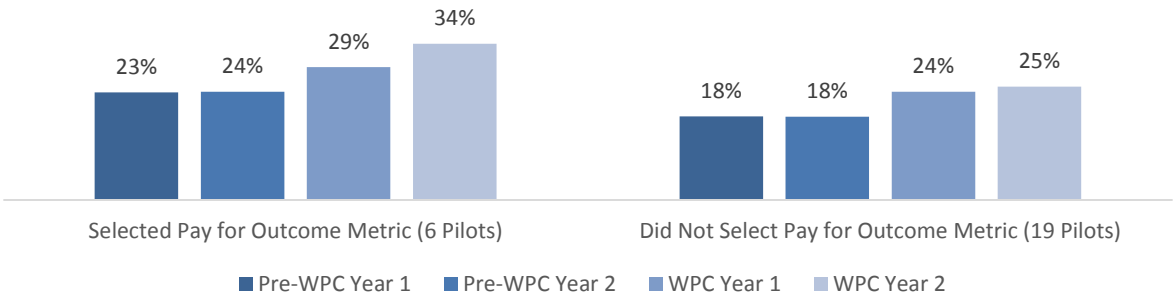
Exhibit 136: Unadjusted Rates of Engagement of Alcohol and Other Drug Dependence Treatment for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal claims and encounter data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

When examining IET-30 among PY 2 enrollees by whether Pilots have a P4O for a similar performance measure, rates among Pilots with P4O were overall slightly higher and increased more after WPC enrollment (Exhibit 137).

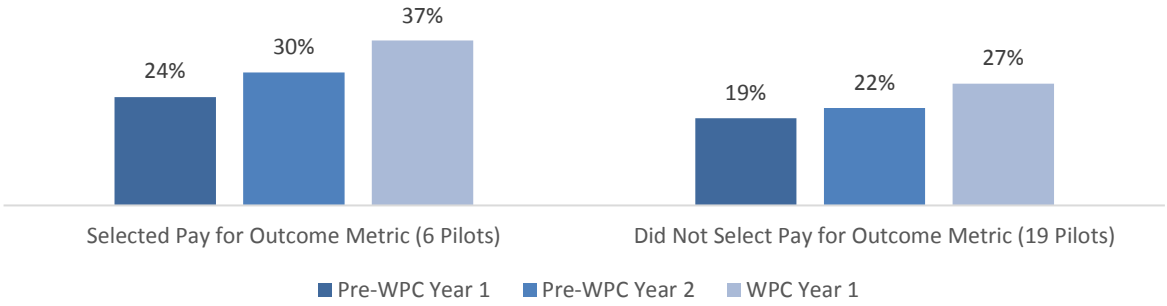
Exhibit 137: Unadjusted Rates of Engagement of Alcohol and Other Drug Dependence Treatment for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 15 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Among PY 3 enrollees, slightly higher rates and a large increase after WPC enrollment was observed among Pilots with a P4O (Exhibit 138).

Exhibit 138: Unadjusted Rates of Engagement of Alcohol and Other Drug Dependence Treatment for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 77,782 person-years with a diagnosis of alcohol or other drug dependence and 35,510 person-years with initiation of treatment among WPC enrollees with sufficient Medi-Cal claims and encounter data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 15 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Examining the IET rates for all WPC enrollees after adjusting for enrollee and Pilot characteristics showed similar patterns of slight increase or steady rates in the Pre-WPC Years and overall higher rates in the WPC Years (Appendix K, Exhibit 1). While the unadjusted rates increased from WPC Year 1 to WPC Year 2 for PY 2 enrollees, the adjusted rates among all enrollees remained steady or showed a slight decline.

Comparison of Adjusted Trends in WPC Metrics Between WPC Enrollees and Controls, Before and After WPC Enrollment

UCLA compared adjusted WPC metrics between WPC enrollees and a control group of Medi-Cal enrollees before and during WPC enrollment using the difference-in-difference (DD) methodology (Appendix A). The control group was selected using WPC enrollee demographics, health conditions, and service utilization. The baseline and WPC enrollment period were constructed as described in the previous section. Each individual in the control group with similar characteristics as the WPC enrollee was examined for the same time periods.

To conduct the DD analyses, UCLA created a final analytic sample from a master dataset of over 4.6 million Medi-Cal enrollees who had either enrolled in WPC or met specific criteria consistent with Pilot target populations (Appendix A). The WPC enrollee and control group sample sizes and characteristics are shown in the Appendix A, Exhibit 3 and showed relatively similar proportions overall, with some differences in age, race/ethnicity, and primary language.

Two better care universal metrics could be calculated following DHCS metric-specifications, including metrics 2.3: Follow-Up after Mental Illness Hospitalization – 7-Day Follow-Up (FUH-7), 2.3: Follow-Up after Mental Illness Hospitalization – 30-Day Follow-Up (FUH-30), 2.4: Initiation of Alcohol and Other Drug Dependence (IET-14), and 2.4: Engagement of Alcohol and Other Drug Dependence (IET-30). Detailed DD results can be found in Appendix K.

Assessment of differences in the universal metric values before (average of Pre-WPC Years) and after WPC (average of WPC Years) implementation indicated significant increases in all four measures (Exhibit 139). Specifically, the rate of FUH-7 increased among WPC enrollees (3.44%), but no significant increase was observed in the control group (0.51%). The increase for WPC enrollees was significantly greater (DD: 2.94%). Assessing the change in FUH-7 rate from WPC Year 1 to WPC Year 2 indicated that this rate remained steady for WPC enrollees and increased by 5% for the control group, a significantly larger increase for the later (data not shown).

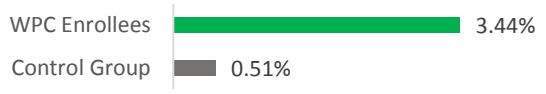
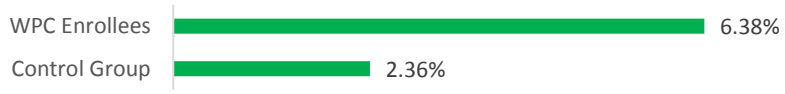
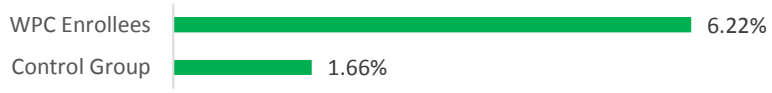
The data showed that the rate of FUH-30 increased after WPC for both WPC enrollees (7.14%) and the control group (4.36%) and the increase for WPC enrollees was significantly greater (DD: 2.78%). Assessing the change in FUH-30 rate from WPC Year 1 to WPC Year 2 indicated that this

rate increased by 3% for WPC enrollees and 6% for the control group, a significantly larger increase for the later (data not shown).

The rate of IET-14 among WPC enrollees and control group also increased after WPC, and the increase for WPC enrollees was significantly greater than the control group (DD: 4.01%). Assessing the change in IET-14 rate from WPC Year 1 to WPC Year 2 indicated that this rate decreased by 3% for WPC enrollees and increased by 3% for the control group, a significantly larger increase for the later (data not shown).

Similarly, the rate of IET-30 for WPC enrollees and control group also increased after WPC, and the increase for WPC enrollees was significantly greater (DD: 4.56%). Assessing the change in IET-30 rate from WPC Year 1 to WPC Year 2 indicated that this rate remained steady for both WPC enrollees and the control group (data not shown).

Exhibit 139: Difference-in-Difference Analyses of Universal Metrics

WPC Universal Metrics		
2.3 – Follow-Up after Mental Illness Hospitalization – Within 30 Days of Discharge (FUH-30)	*WPC: N = 22,189* *Control: N = 27,958*	
		DD: 2.78%*
2.3 – Follow-Up after Mental Illness Hospitalization – Within 7 Days of Discharge (FUH-7)	*WPC: N = 22,189* *Control: N = 27,958*	
		DD: 2.94%*
2.4 – Initiation of Alcohol and Other Drug Dependence (IET-14)	*WPC: N = 77,782* *Control: N = 114,211*	
		DD: 4.01%*
2.4 - Engagement of Alcohol and Other Drug Dependence (IET-30)	*WPC: N = 35,510* *Control: N = 51,238*	
		DD: 4.56%*

Not significant before and during WPC within each group (WPC Enrollees or Control Group), $p \geq 0.05$; Intended direction and significant before and during WPC within each group (WPC Enrollees or Control Group), $p < 0.05$

Source: UCLA analysis of Medi-Cal data, July to August 2019.

Notes: N: number of person-years analyzed per metric, DD: difference-in-difference. * Denotes $p < 0.05$ for difference-in-difference analysis

Trends in WPC Pilot-Reported Metrics

To assess better care metrics that UCLA could not replicate using Medi-Cal data, UCLA calculated the weighted average values for one universal and one variant metrics using Pilot-reported data (Exhibit 140). Some Pilots did not report metrics for reasons such as no enrollment or program activities during the reporting time period or lack of data in that time period. See Appendix B for further details on reporting for each metric, including which Pilots reported on each metric during each measurement year.

Pilot-reported metrics differ from those created based on Medi-Cal data for multiple reasons. Because these metrics were reported in the aggregate by each Pilot, they could not be reported for PY 2 and PY 3 enrollees separately. In addition, they were based on a different population of enrollees in each measurement year and were reported for a calendar year rather than years before and after WPC enrollment. Furthermore, Pilots reported one year of baseline and UCLA used two years of baseline. Pilots also reported baseline values based on Medi-Cal enrollment and used WPC enrollment for reporting years, while UCLA used Medi-Cal enrollment for all years.

Exhibit 140: Pilot-Reported Universal and Variant Metrics That Indicate Better Care

Universal vs. Variant	Metric Name and Number	Description	Baseline Year	Reporting Years	Numbers of Pilots Reporting by Year	Improvement Measured by Increase or Decrease
Universal	2.5 Comprehensive Care Plan (CCP)	CCP-E: Percent of enrollees who received a CCP (accessible by their entire care team), within 30 days of enrollment	PY 2	PY 3	20 in PY 2 24 in PY 3	Increase
		CCP-A: Percent of enrollees who received a CCP (accessible by their entire care team) within 30 days of the enrollee's anniversary of enrollment in WPC	PY 3	N/A	19 in PY 3	Increase
Variant	3.1.7: Major Depressive Disorder Suicide Risk	MDD: Parentage of enrollees aged 18 and older with a diagnosis of MDD with a suicide risk assessment completed during the visit in which a	PY 1 (2016)	PY 2, PY 3	19 in PY 1 18 in PY 2 22 in PY 3	Increase

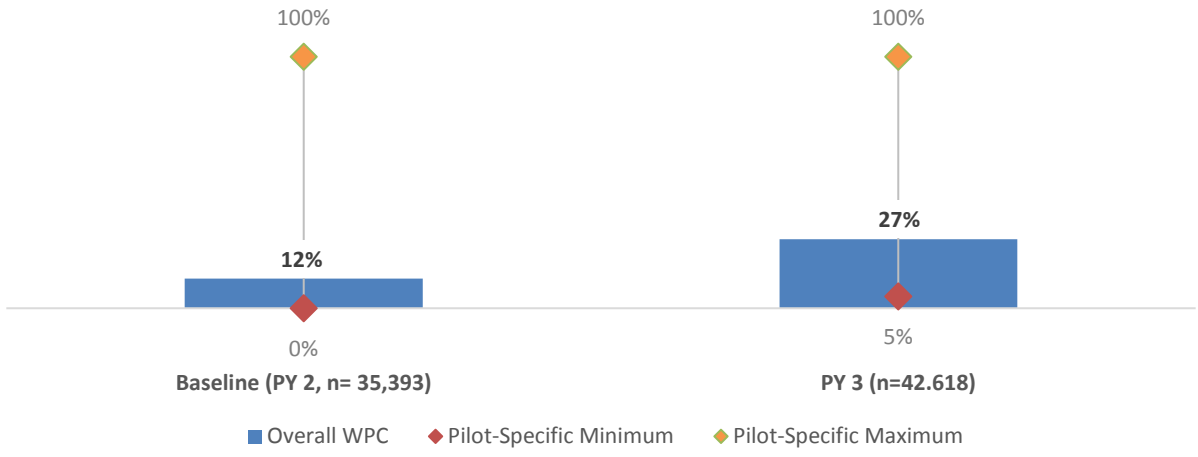
Universal vs. Variant	Metric Name and Number	Description	Baseline Year	Reporting Years	Numbers of Pilots Reporting by Year	Improvement Measured by Increase or Decrease
	Assessment (MDD)	new diagnosis or recurrent episode was identified				

Source: PY 1 (baseline), PY 2, and PY 3 Annual WPC Variant and Universal Metric Reports and Whole Person Care Universal and Variant Metrics Technical Specifications (March 22, 2019).

Universal Metric 2.5: Comprehensive Care Plan (CCP)

All Pilots were required to report on the percent of enrollees who received a comprehensive care plan, accessible by their entire care team, (1) within 30 days of enrollment (CCP-E) and (2) within 30 days of the enrollee's anniversary of enrollment in WPC (CCP-A). CCP-A data could only be reported in PY 3. The overall CCP-E rate for WPC increased from 12% in PY 2 to 27% in PY 3 (Exhibit 141). When examining rates by individual Pilots, CCP-E varied from a low of 0% to a high of 100% during baseline and from 5% to 100% in PY 3. The low rates for CCP-E were mainly influenced by the two large Pilots, which had rates of 1.2% and 9.3% in PY 2, respectively. In PY 3, the rates for these two Pilots increased to 6.3% and 27.2%, respectively. The overall CCP-A rate for WPC was 43% in PY 3 (data not shown).

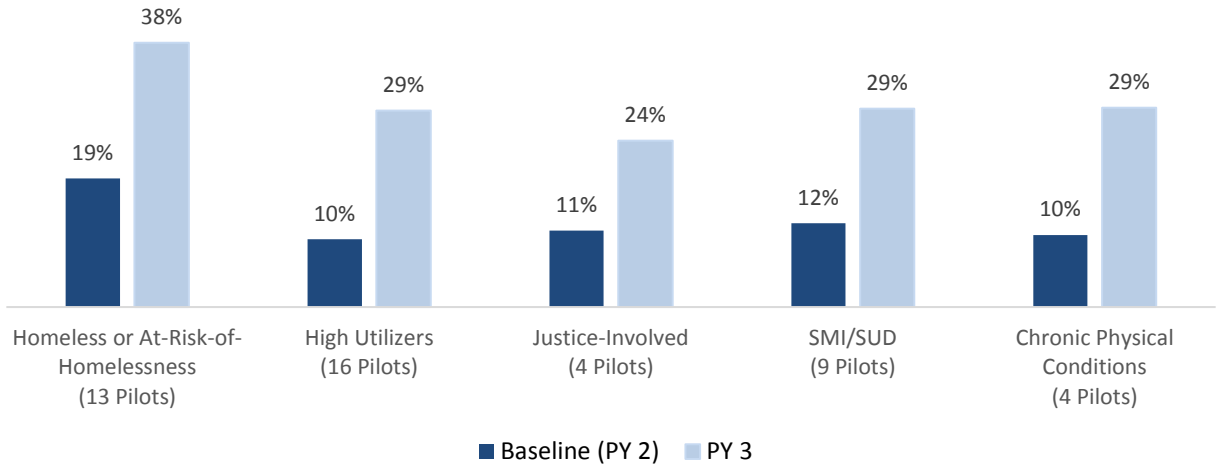
Exhibit 141: Percent of Enrollees Who Received a Comprehensive Care Plan Within 30 Days of Enrollment, by Program Year



Source: PY 2 and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: The comprehensive care plan was to be accessible by the entire care team. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. The denominator size is shown as sample size per year. Appendix B, Exhibit 16 provides details on which Pilots reported in each year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot. The rate of 0% indicates that no enrollees received a comprehensive care plan within 30 days of enrollment during the baseline year.

Examining the CCP-E rate by grouping Pilots that selected a target population also showed an increase from PY 2 to PY 3, but the increase was higher for Pilots that selected the homeless or at-risk-of-homelessness, high utilizers, and chronic physical condition populations and lower for Pilots that selected justice-involved and SMI/SUD populations (Exhibit 142).

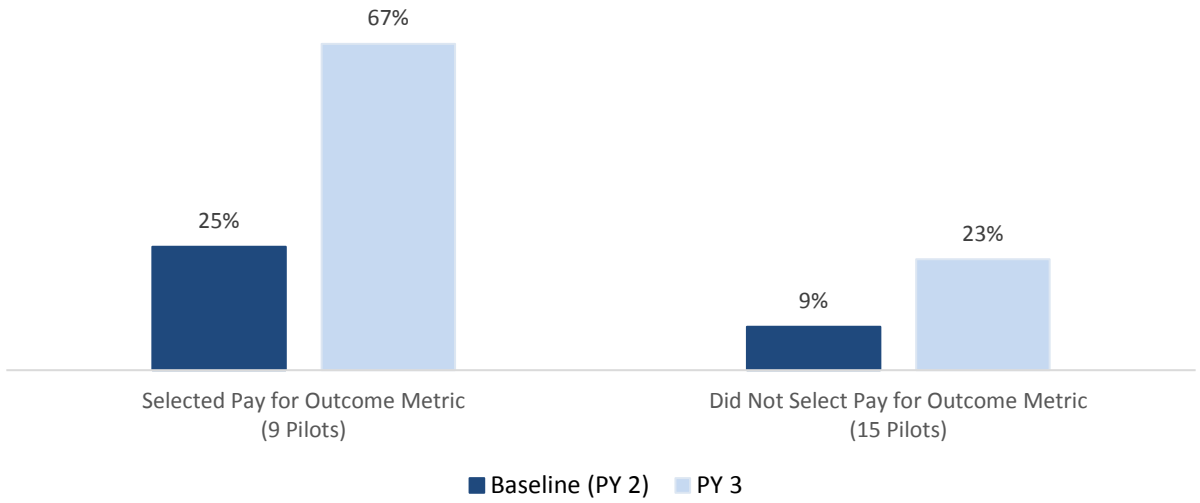
Exhibit 142: Percent of Enrollees Who Received a Comprehensive Care Plan, Within 30 Days of Enrollment, Among Pilots That Selected Specific Primary Target Populations



Source: PY 2 and PY 3 Annual WPC Variant and Universal Metric Reports.
Note: Data indicated rates among Pilots that selected a given target population and do not reflect rates among enrollees in a target population. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 16 provides details on which Pilots reported in each year. Pilots can have multiple primary target populations, and thus the primary target population groups are not mutually exclusive. SMI/SUD is severe mental illness and/or substance use disorder.

Of the 24 Pilots that reported the CCP-E metric, nine had P4O incentives for a similar performance measure. Pilots with a P4O for this metric reported a higher rate (from 25% in PY 2 to 67% in PY 3) relative to those without a P4O (from 9% in PY2 to 23% in PY 3, Exhibit 143). Two large Pilots with low rates did not have a P4O incentive for this metric, contributing to the low rates observed in this group. The CCP-A rate in PY 3 was 52% for Pilots that had a related P4O, and 41% for Pilots that did not have a related P4O (data not shown).

Exhibit 143: Percent of Enrollees Who Received a Comprehensive Care Plan, Within 30 Days of Enrollment, by Whether Pilot Had Selected Pay for Outcome Incentives

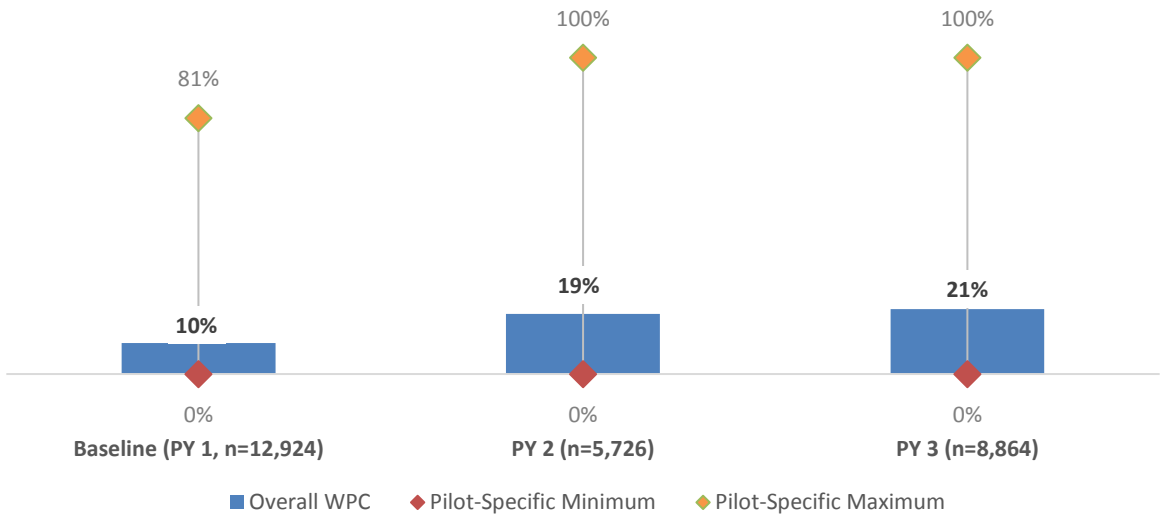


Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: The comprehensive care plan was to be accessible by the entire care team. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 16 provides details on which Pilots reported in each year. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Variant Metric 3.1.7: Adult Major Depressive Disorder: Suicide Risk Assessment

A subset of 23 WPC Pilots elected to report the percent of enrollees age 18 or older with a diagnosis of major depressive disorder (MDD) who had a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. The overall MDD rate increased from 10% in baseline to 19% in PY 2, and increased again to 21% in PY 3 (Exhibit 144). There was variation in MDD by Pilot, ranging from a low of 0% in all measurement years to a high of 100% in PY 2 and PY 3. Many Pilots had less than 11 enrollees with a diagnosis of major depressive disorder during each measurement year, making them susceptible to high variation in this metric. One of the Pilots, which accounted for between 47% and 68% of all enrollees with a diagnosis of major depressive disorder each year had consistently low rates of 0.3%, 1.0% and 1.3% for baseline, PY 2 and PY 3, respectively. Without this Pilot, the MDD rate increased from 30% to 48.2% from baseline to PY 3.

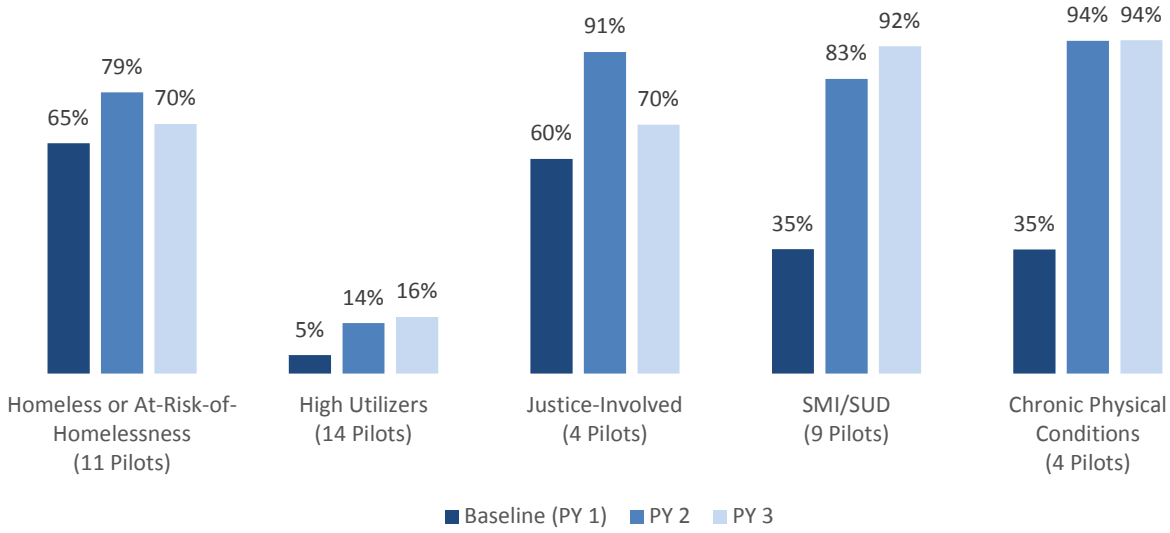
Exhibit 144: Percent of Adult Enrollees with a Diagnosis of Major Depressive Disorder That Received a Suicide Risk Assessment During the Visit in Which a New Diagnosis or Episode was Identified, by Program Year



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Note: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 7 provides details on which Pilots reported in each year. The denominator size is shown as sample size per year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot.

Examining MDD rates by grouping Pilots that selected a target population by Pilot groups (Exhibit 145). While all Pilot groups showed gains in MDD from baseline, the gains were more substantial among Pilots that selected SMI/SUD and chronic physical conditions target populations (from 35% to 92% and 94%, respectively). Rates peaked for Pilots selecting homeless or at-risk-of-homelessness and justice-involved as a target population during PY 2. The overall low rates among Pilots that targeted high utilizers were due to low rates in one large Pilot.

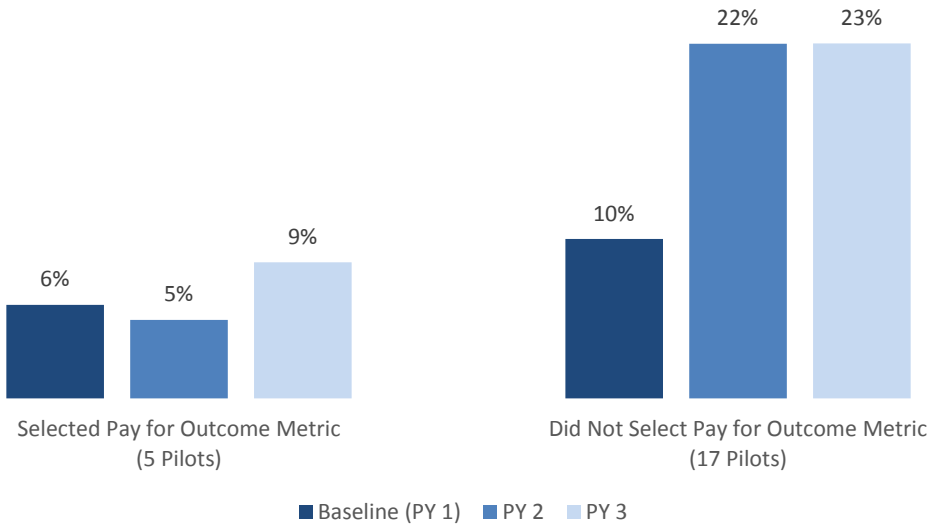
Exhibit 145: Percent of Adult Enrollees with a Diagnosis of Major Depressive Disorder That Received a Suicide Risk Assessment During the Visit in Which a New Diagnosis or Episode Was Identified, Among Pilots That Selected Specific Primary Target Populations



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Note: Data indicated rates among Pilots that selected a given target population and do not reflect rates among enrollees in a target population. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 7 provides details on which Pilots reported in each year. Pilots can have multiple primary target populations, and thus the primary target population groups are not mutually exclusive. SMI/SUD is severe mental illness and/or substance use disorder.

Of the 23 Pilots that reported on MDD, five had P4O incentives for a similar performance measure. Overall, MDD rates were lower among Pilots with a P4O and increases from PY 1 to PY 3 were much lower among these Pilots (from 6% to 9%, Exhibit 146). The low rates among Pilots with a P4O were largely influenced by one Pilot, which accounted for the majority of this population and had rates below 1% for all measurement years. Among Pilots without a P4O, the MDD increased from 10% to 23% from PY 1 to PY 3, with rates primarily being influenced by one large Pilot.

Exhibit 146: Percent of Adult Enrollees with a Diagnosis of Major Depressive Disorder That Received a Suicide Risk Assessment During the Visit in Which a New Diagnosis or Episode Was Identified, by Whether Pilot Had Selected Pay for Outcome Incentives



Source: PY 1 (Baseline), PY2 Annual, and PY3 Annual WPC Variant and Universal Metric Reports.
Note: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 7 provides details on which Pilots reported in each year. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Chapter 12: Better Health

WPC Pilots aimed to "reduce inappropriate emergency and inpatient utilization" and "improve health outcomes for the WPC population." This chapter addresses the following evaluation question: "To what extent did the Pilots improve beneficiary care and health outcomes, including reduction of avoidable utilization of emergency and inpatient services, and improve outcomes such as controlled blood pressure and Hemoglobin A1c (HbA1c)?" Data sources for this chapter included *WPC Enrollment and Utilization Reports* from PY 2 – PY 3 *and* Medi-Cal enrollment and claims that were used to create two universal metrics (2.1 – Ambulatory Care-Emergency Department Visits and 2.2 – Inpatient Utilization – General/Acute Care) and one variant metric (3.1.1 – All-Cause Readmissions). The *Annual WPC Variant and Universal Metric Reports* submitted by Pilots to DHCS at the end of PY 2, and PY 3 were used to report on five variant metrics that could not be created using Medi-Cal enrollment and claims data. These included 3.1.2 – Decrease Jail Incarcerations, 3.1.3 – Overall Beneficiary Health, 3.1.4 – Controlling High Blood Pressure, 3.1.5 – Comprehensive Diabetes Care, and 3.1.6 – PHQ-9/Depression Remission at 12 Months. Pilot-reported metrics on emergency department visits, hospitalizations, and readmissions were not reported because they were found to be heavily dependent on data sharing agreements and data sharing capacity during the first three years of WPC and were therefore incomplete. The remaining Pilot-reported metrics could not be created using Medi-Cal data. These data were often based on electronic medical records or chart review and were considered complete and reliable. For additional detail on data sources and methodology, please see the Analytic Methods and Appendices A and B.

Unadjusted Trends in WPC Metrics Using Medi-Cal Data, Before and After WPC Enrollment

UCLA used Medi-Cal data to replicate better health metrics following DHCS specifications, when possible. Two universal metrics, 2.1 (ambulatory care) and 2.2 (inpatient utilization – general hospital/acute care), could be calculated. One variant metric, 3.1.1 (all-cause readmissions), could be calculated (Exhibit 147).

For these analyses, UCLA identified pre- and post-WPC enrollment years for each WPC enrollee based on their individual date of first enrollment into WPC. Therefore, baseline periods reflected two years before (Pre-WPC Year 2) and one year before WPC enrollment (Pre-WPC Year 1). The enrollment period included one year after (WPC Year 1) and two years after WPC enrollment (WPC Year 2). All measurement years were based on Medi-Cal enrollment and not WPC enrollment.

Ultimately, 96,868 enrollees with sufficient Medi-Cal data in both the baseline and enrollment time periods were used for these analyses, but the denominator was further reduced based on DHCS metric specification. For additional detail on data sources and methodology, please see Appendix A, and for a complete list of metrics by Pilot and target populations, please see Appendix I.

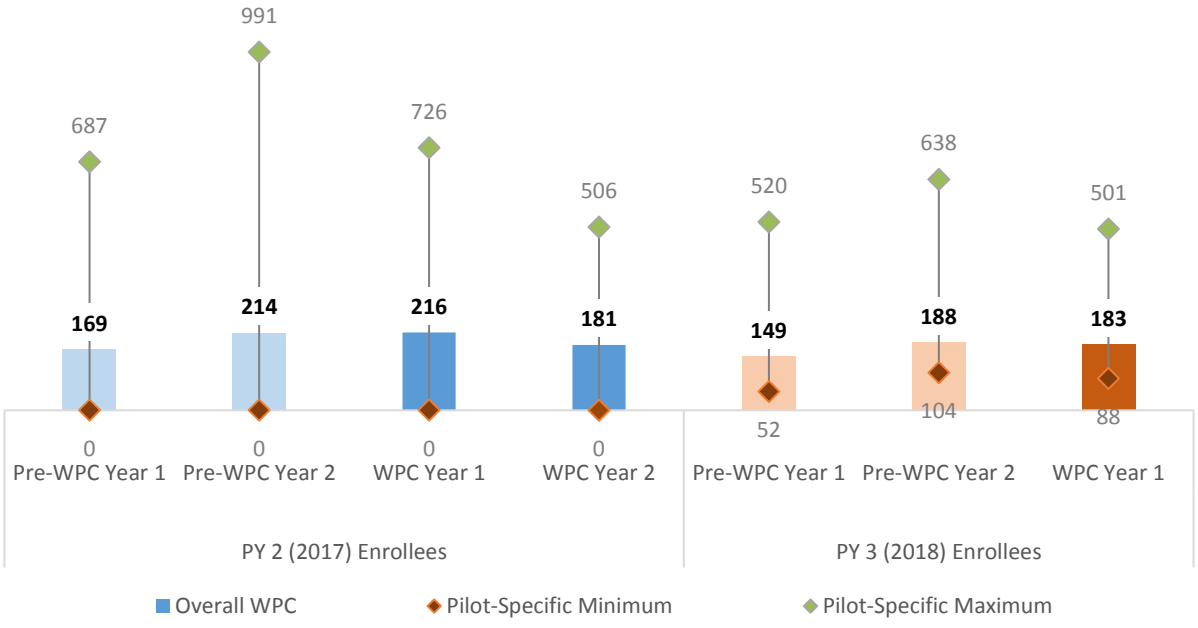
Exhibit 147: Universal and Variant Metrics that Indicate Better Health Using Medi-Cal Data

Universal vs. Variant	Metric Name and Number	Description	Improvement Measured by Increase or Decrease
Universal	2.1: Ambulatory Care Emergency Department Visits per 1,000 Member Months (AMB-ED)	AMB-ED: Utilization of ambulatory care ED visits	Decrease
Universal	2.2: Inpatient Utilization per 1,000 Member Months (IPU)	IPU: Utilization of acute inpatient care and services	Decrease
Variant	3.1.1: All-Cause Readmissions (ACR)	ACR: Number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days	Decrease

Universal Metric 2.1: Ambulatory Care Emergency Department Visits per 1,000 Member Months (AMB-ED)

All WPC Pilots were required to report the AMB-ED rate, and UCLA created this metric using Medi-Cal data. Among PY 2 enrollees, AMB-ED rates showed an ongoing increase from Pre-WPC Year 1 to Pre-WPC Year 2, with a lesser increase in WPC Year 1 (from 169 to 214 to 216, Exhibit 148). However, this rate decreased to 181 in WPC Year 2. Among PY 3 enrollees, the same pattern was observed in the Pre-WPC years, but this rate declined in WPC Year 1. There was significant variability by Pilot for each year and enrollee group. For example, this rate ranged from zero in WPC Year 2 to 991 in Pre-WPC Year 2 for PY 2 enrollees and from 52 in Pre-WPC Year 1 to 638 in Pre-WPC Year 2 for PY 3 enrollees. High variability by Pilot in PY 2 is largely due to some Pilots having low enrollment numbers that year.

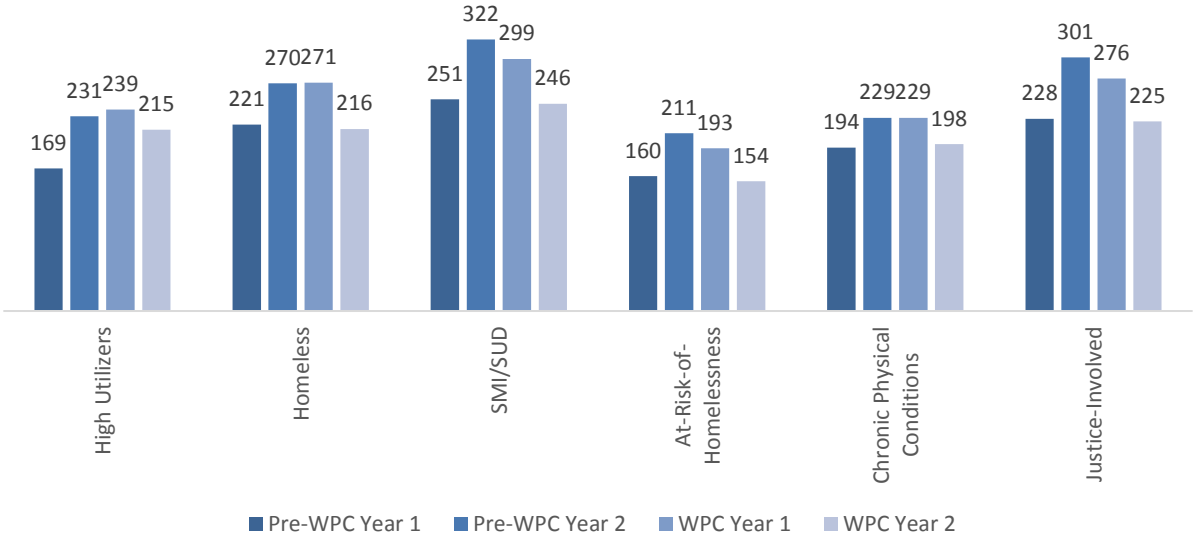
Exhibit 148: Unadjusted Rates of Emergency Department Visits per 1,000 Medi-Cal Member Months for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. A rate of 0 indicates that there were no ED visits among WPC enrollees for the measurement year.

The same pattern of increase prior to WPC enrollment can be observed in the Pre-WPC Years when examining AMB-ED rates among PY 2 enrollees by target populations (Exhibit 149). However, this rate started declining in WPC Year 1 rather than WPC Year 2 among the SMI/SUD, at-risk-of-homelessness, and justice-involved target populations.

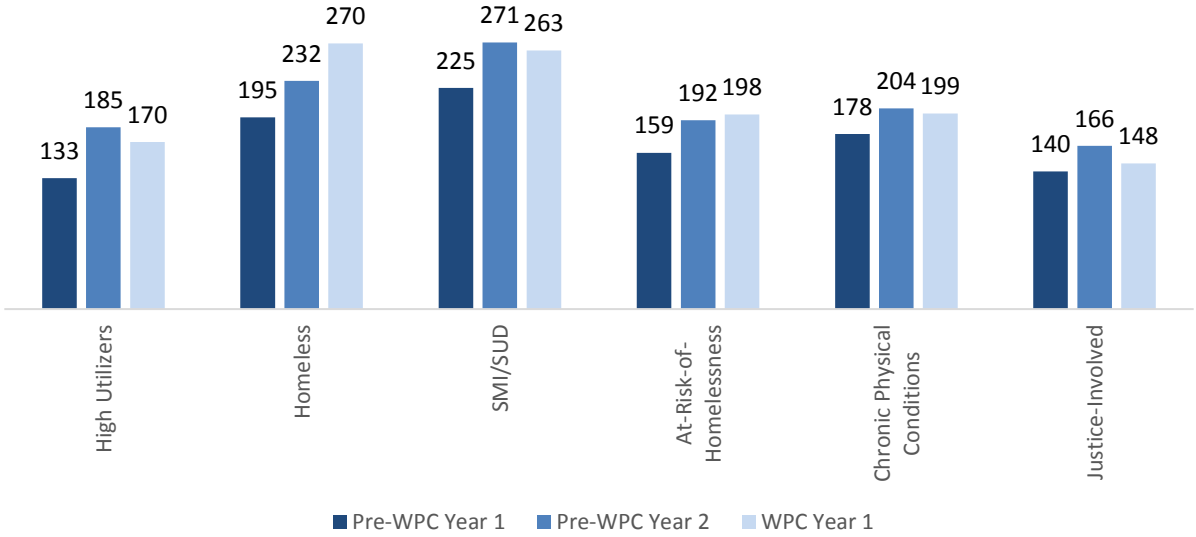
Exhibit 149: Unadjusted Rates of Emergency Department Visits per 1,000 Medi-Cal Member Months for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

The same pattern of increase prior to WPC enrollment can be observed in the Pre-WPC Years for AMB-ED rates among PY 3 enrollee target populations (Exhibit 150). In WPC Year 1, this rate declined for high utilizers, SMI/SUD, chronic physical conditions, and justice-involved enrollees but increased for homeless and at-risk-of-homelessness target populations.

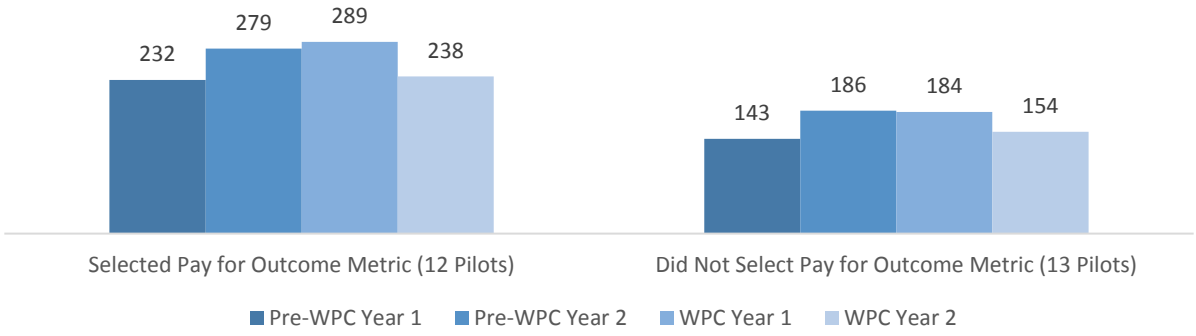
Exhibit 150: Unadjusted Rates of Emergency Department Visits per 1,000 Medi-Cal Member Months for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

For WPC Pilots that selected AMB-ED as a pay-for-outcome (P4O) metric among PY 2 enrollee target populations, AMB-ED increased from Pre-WPC Year 1 to Pre-WPC Year 2 and WPC Year 1 (from 232 to 279 to 289, Exhibit 151). However, this rate decreased to 238 in WPC Year 2. Among WPC pilots without the P4O, the same pattern was observed in the Pre-WPC years, but this rate declined in both WPC Year 1 and WPC Year 2. Overall AMB-ED rates were higher among the Pilots with a P4O, suggesting that Pilots that focused on this metric also targeted individuals with higher ED utilization. The decline from WPC Year 1 to WPC Year 2 was greater among Pilots with a P4O compared to Pilots without a P4O.

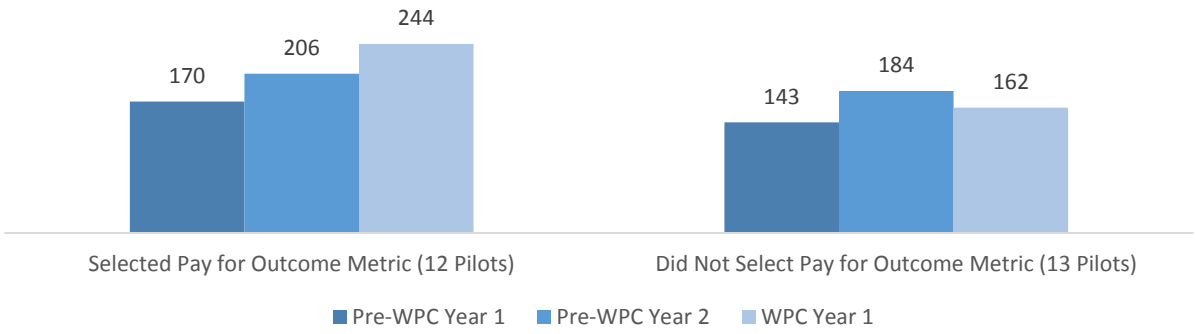
Exhibit 151: Unadjusted Rates of Emergency Department Visits per 1,000 Medi-Cal Member Months for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 12 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

For WPC Pilots that selected AMB-ED as a P4O metric among PY 3 enrollee target populations, AMB-ED increased from Pre-WPC Year 1 to Pre-WPC Year 2 and WPC Year 1 (from 170 to 206 to 244, Exhibit 152). Among WPC Pilots without a P4O, the same pattern was observed in the Pre-WPC Years, but this rate declined in WPC Year 1.

Exhibit 152: Unadjusted Rates of Emergency Department Visits per 1,000 Medi-Cal Member Months for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



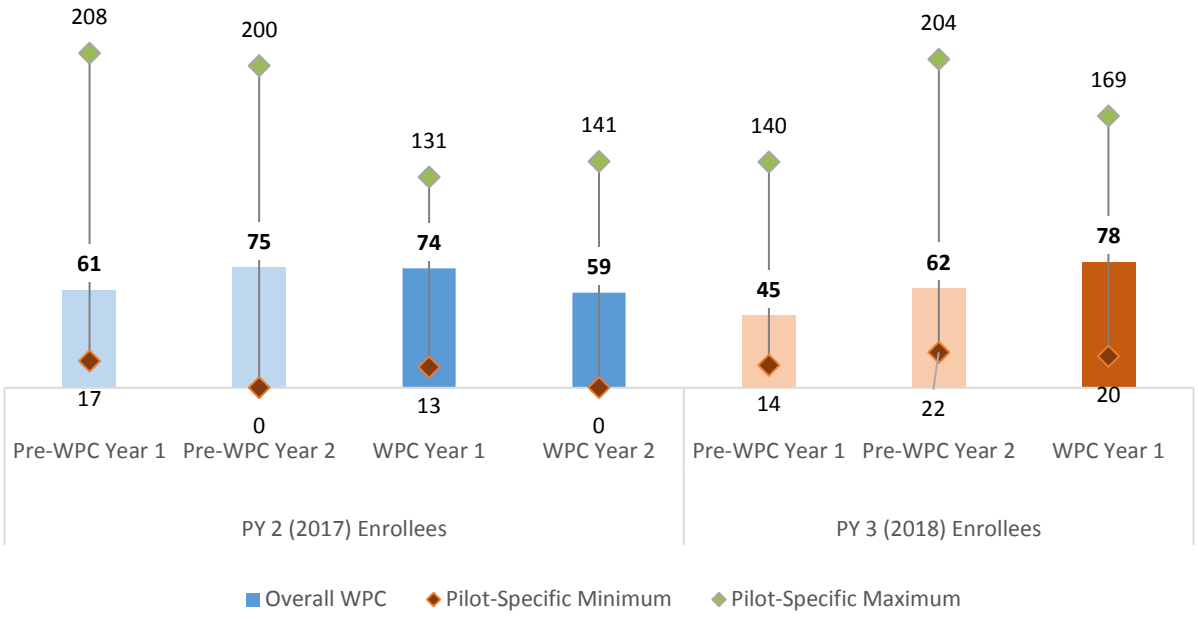
Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 12 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Examining the AMB-ED rates for all WPC enrollees after adjusting for enrollee and Pilot characteristics showed similar patterns of increase prior to WPC enrollment in Pre-WPC Years, a lesser increase in WPC Year 1, and a decline in WPC Year 2 (Appendix K, Exhibit 1). The highest observed rate of AMB-ED in WPC Year 1 is likely because WPC is designed to enroll Medi-Cal beneficiaries with highest levels of utilization, and the data indicate these enrollees had an escalating AMB-ED rate prior to their enrollment. The receipt of WPC services in WPC Year 1 is likely to have subsequently resulted in a reduction in AMB-ED in WPC Year 2.

Universal Metric 2.2: Inpatient Utilization per 1,000 Member Months

All WPC Pilots were required to report inpatient utilization per 1,000 member months (IPU), and UCLA successfully created this metric using Medi-Cal data. Among PY 2 enrollees, IPU increased prior to WPC enrollment in Pre-WPC Years (from 61 to 75) but decreased in WPC Years (from 74 to 59, Exhibit 153). For PY 3 enrollees, the same pattern was observed prior to WPC enrollment in Pre-WPC Years, but IPU increased further in WPC Year 1 (from 45 to 62 to 78). IPU varied by pilot; for example, it ranged from 0 in Pre-WPC Year 2 and WPC Year 2 to 208 in Pre-WPC Year 1 for PY 2 enrollees.

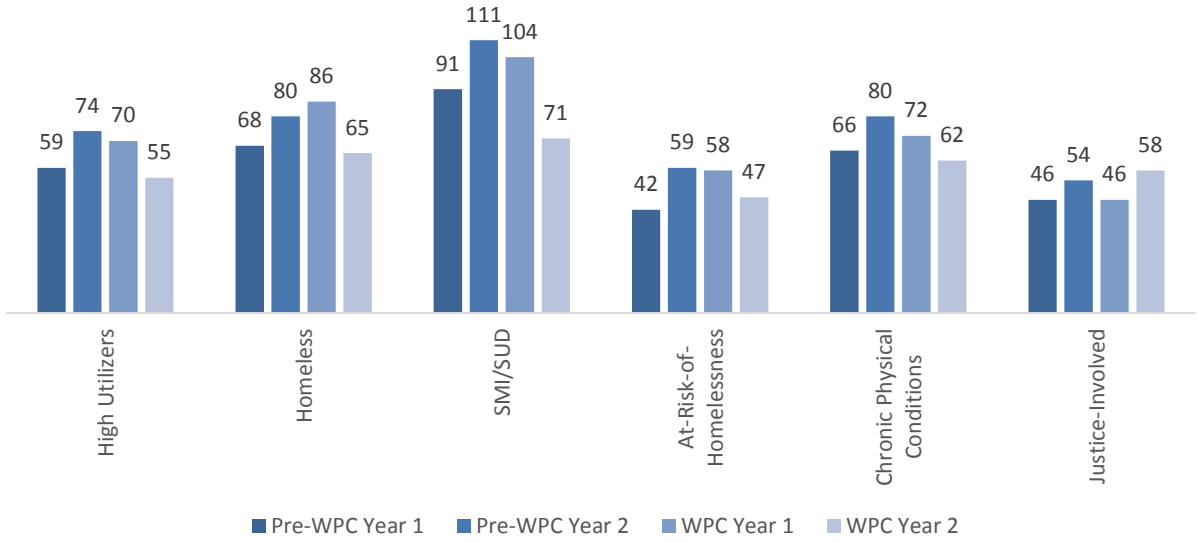
Exhibit 153: Unadjusted Rates of Inpatient Utilization per 1,000 Medi-Cal Member Months for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. A rate of 0 indicates that there were no hospitalizations among WPC enrollees for the measurement year.

When examining rates by PY 2 enrollee target populations, IPU rates decreased in the WPC Years after increasing prior to WPC enrollment in the Pre-WPC years for all target populations, except for enrollees identified as justice-involved (Exhibit 154). A steeper decline from WPC Year 1 to WPC Year 2 was observed for PY 2 enrollees identified as SMI/SUD compared to other target populations (from 104 to 71).

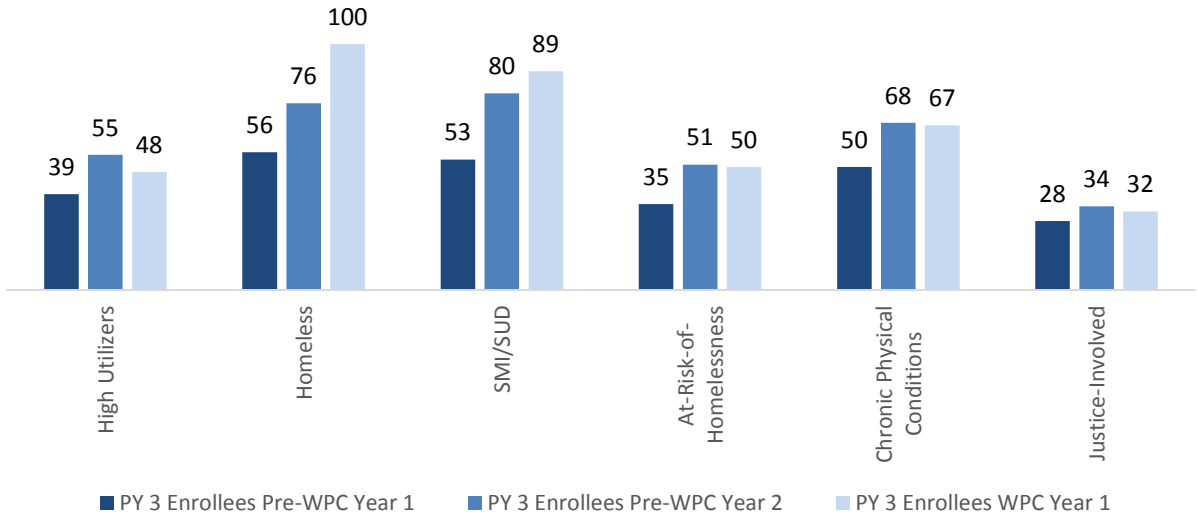
Exhibit 154: Unadjusted Rates of Inpatient Utilization per 1,000 Medi-Cal Member Months for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

When examining IPU rates by PY 3 enrollee target populations, rates declined in WPC Year 1 after increasing prior to WPC enrollment during the Pre-WPC Years for enrollees identified as high utilizers, at-risk-of-homelessness, chronic physical conditions, and justice-involved (Exhibit 155). However, rates continued to increase in WPC Year 1 for PY 3 enrollees identified as homeless and SMI/SUD.

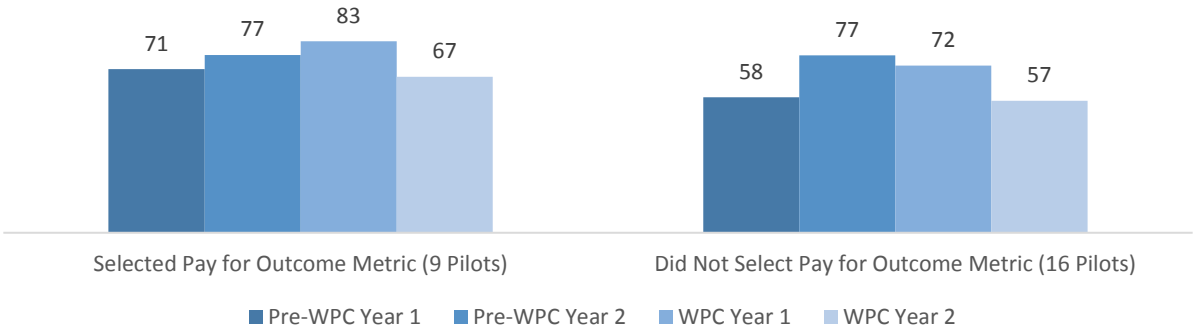
Exhibit 155: Unadjusted Rates of Inpatient Utilization per 1,000 Medi-Cal Member Months for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

For WPC Pilots that selected IPU as a P4O metric among PY 2 enrollee target populations, IPU increased prior to WPC enrollment from Pre-WPC Year 1 to Pre-WPC Year 2 and WPC Year 1 (from 71 to 77 to 83, Exhibit 156). However, this rate decreased to 67 in WPC Year 2. Among WPC pilots that did not select IPU as a P4O metric, the same pattern was observed in the Pre-WPC years, but this rate declined starting in WPC Year 1, then continued to decrease in WPC Year 2.

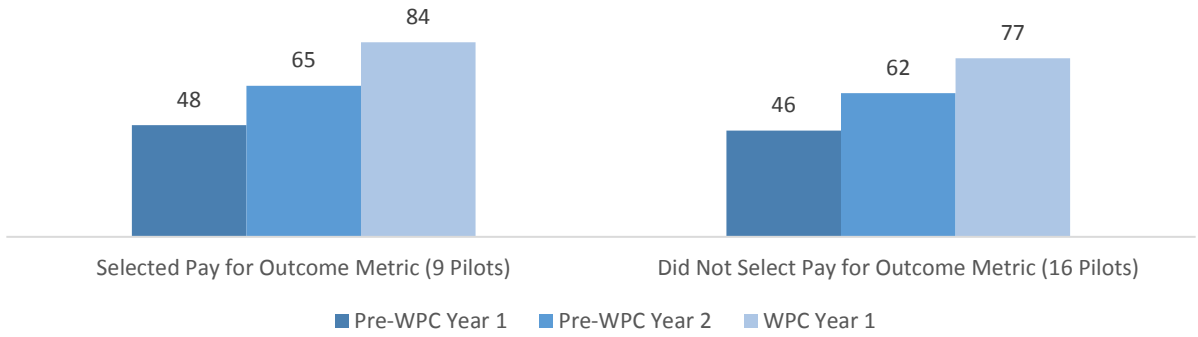
Exhibit 156: Unadjusted Rates of Inpatient Utilization per 1,000 Medi-Cal Member Months for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 12 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

For WPC Pilots that selected IPU as a pay-for-outcome metric among PY 3 enrollee target populations, IPU increased prior to WPC enrollment from Pre-WPC Year 1 to Pre-WPC Year 2 and WPC Year 1 (from 48 to 65 to 84, Exhibit 157). Among WPC pilots that did not select IPU as a pay-for-outcome metric, the same pattern was observed in the Pre-WPC Years and WPC Year 1.

Exhibit 157: Unadjusted Rates of Inpatient Utilization per 1,000 Medi-Cal Member Months for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



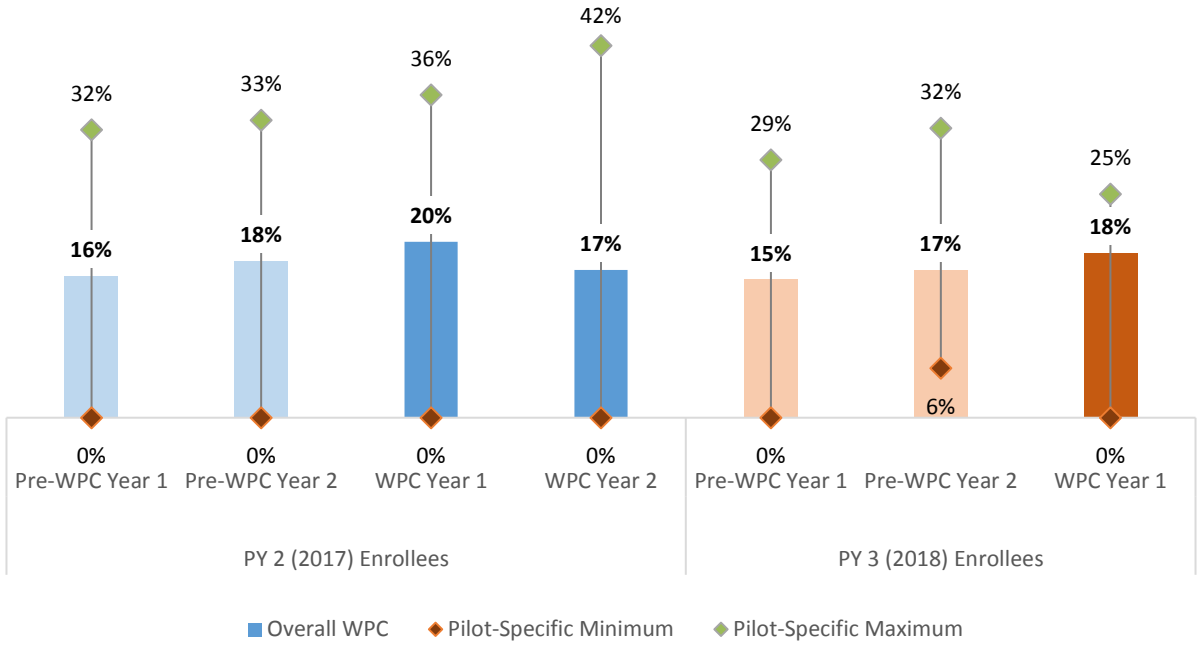
Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 12 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Examining the IPU rates for all WPC enrollees after adjusting for enrollee and Pilot characteristics showed similar patterns of increase prior to WPC enrollment in Pre-WPC Years, a continued increase in WPC Year 1, and a decline in WPC Year 2 (Appendix K, Exhibit 1). The highest observed rate of IPU in WPC Year 1 is likely because WPC is designed to enroll Medi-Cal beneficiaries with highest levels of utilization and the data indicate these enrollees had an escalating IPU rate prior to their enrollment. The receipt of WPC services in WPC Year 1 is likely to have subsequently resulted in a reduction in IPU in WPC Year 2.

Variant Metric 3.1.1: All-Cause Readmissions (ACR)

All-cause readmissions (ACR) are reported for all WPC enrollees to show overall program impact, even though only seven Pilots had elected to report this variant metric. UCLA successfully created this metric using Medi-Cal data. ACR rates increased prior to WPC enrollment in the Pre-WPC Years, and the trend continued in WPC Year 1 for both PY 2 and PY 3 enrollees (Exhibit 158). ACR decreased (from 20% to 17%) in WPC Year 2 for PY 2 enrollees. The variability by Pilot was large, ranging, for example, from 0% to 42% in WPC Year 2 for PY 2 enrollees and from 0% in Pre-WPC Year 1 and WPC Year 1 to 32% in Pre-WPC Year 2 for PY 3 enrollees.

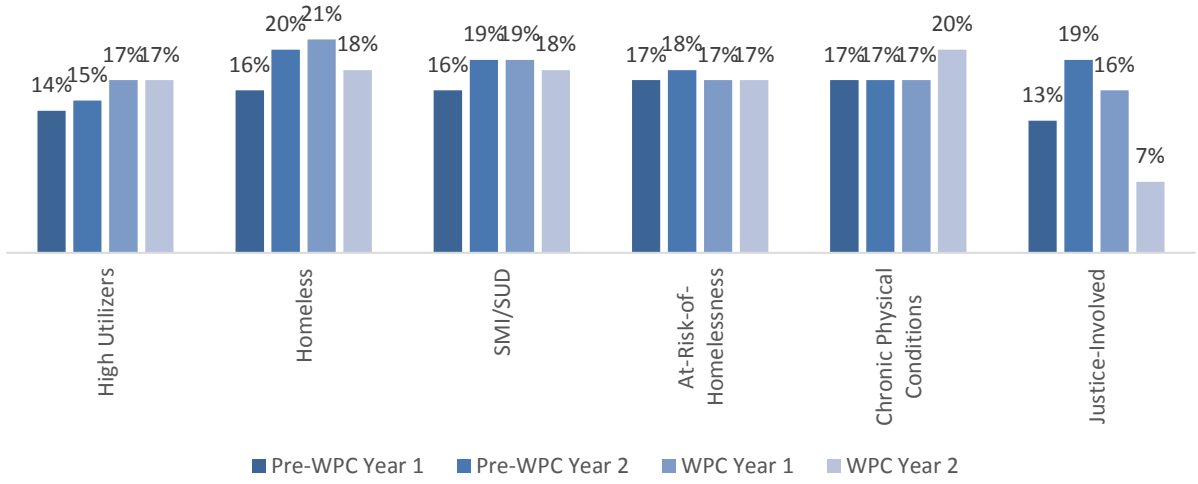
Exhibit 158: Unadjusted Rates of All-Cause Readmissions for PY 2 and PY 3 Enrollees, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. A rate of 0% indicates that there were no readmissions among WPC enrollees for the measurement year.

When examining rates by PY 2 enrollee target populations, ACR rates declined during the WPC Years among enrollees identified as homeless, SMI/SUD, and justice-involved (Exhibit 159). Among enrollees identified as having chronic physical conditions, there was an increase in ACR from 17% to 20% during the WPC Years.

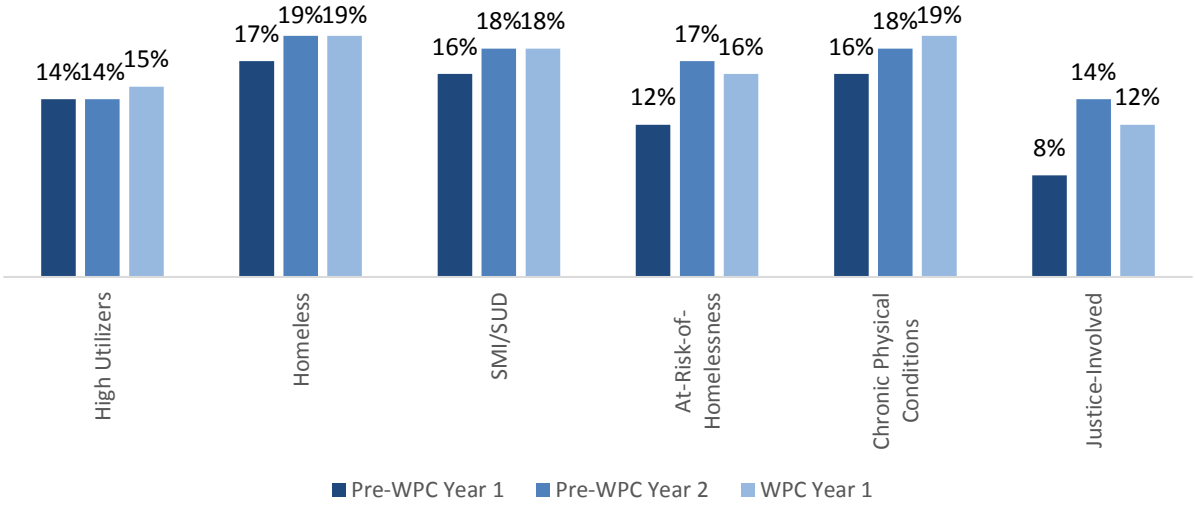
Exhibit 159: Unadjusted Rates of All-Cause Readmissions for PY 2 (2017) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

When examining rates among PY 3 enrollee target populations, ACR rates increased prior to WPC enrollment during the Pre-WPC Years and declined during WPC Year 1 among enrollees identified as at-risk-of-homelessness and justice-involved (Exhibit 160). Among other target populations, ACR rates remained the same or increased by 1% during WPC Year 1.

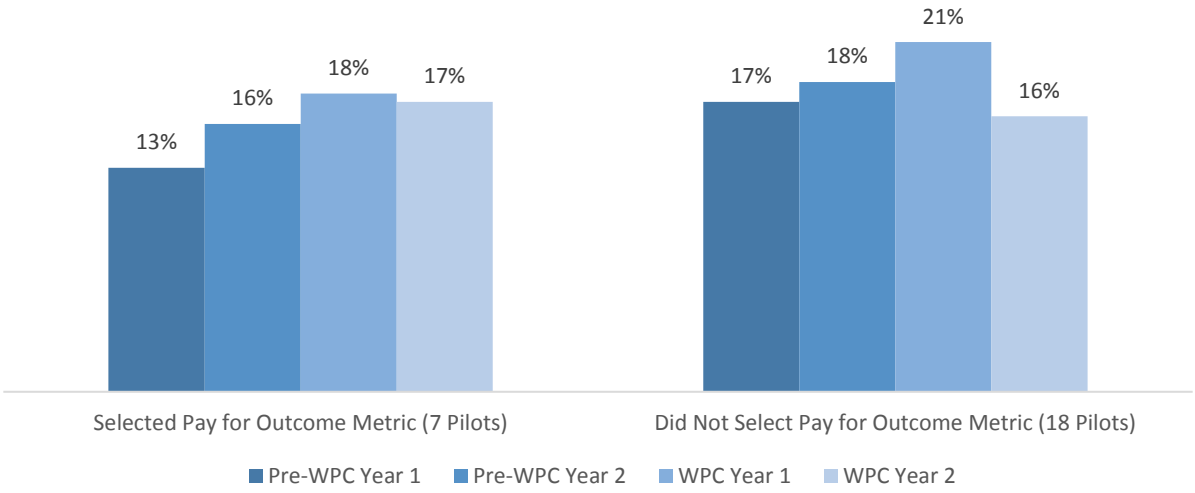
Exhibit 160: Unadjusted Rates of All-Cause Readmissions for PY 3 (2018) Enrollees by Target Population, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Enrollees can be in more than one target population.

For WPC Pilots that selected ACR as a P4O metric among PY 2 enrollee target populations, ACR increased prior to WPC enrollment from Pre-WPC Year 1 to Pre-WPC Year 2 and WPC Year 1 (from 13% to 16% to 18%, Exhibit 161). However, this rate decreased to 17% in WPC Year 2. Among WPC pilots that did not select IPU as a P4O metric, the same pattern was observed in the Pre-WPC Years and WPC Years, with a greater decline in WPC Year 2.

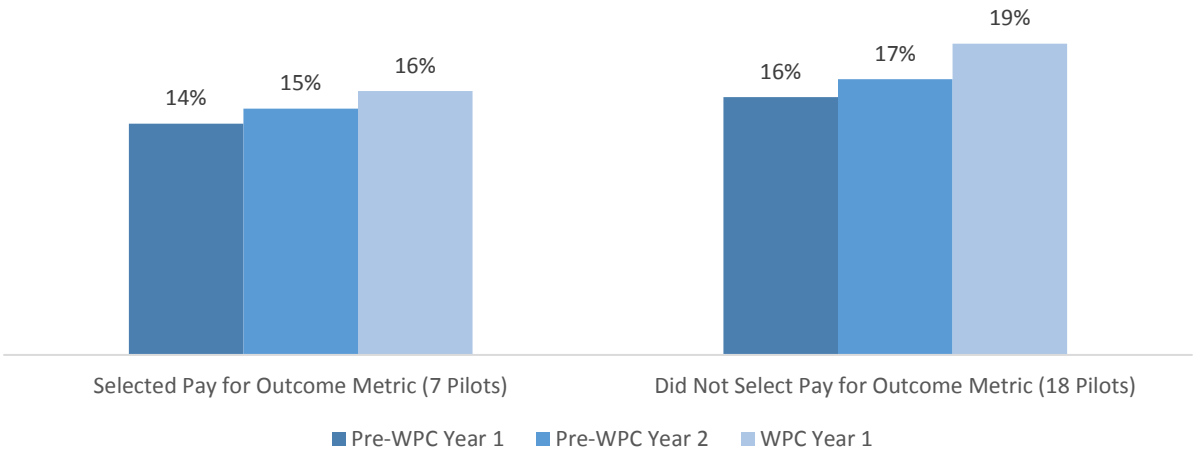
Exhibit 161: Unadjusted Rates of All-Cause Readmissions for PY 2 (2017) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 11 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

For WPC Pilots that selected ACR as a P4O metric among PY 3 enrollee target populations, IPU increased prior to WPC enrollment from Pre-WPC Year 1 to Pre-WPC Year 2 and WPC Year 1 (from 14% to 15% to 16%, Exhibit 162). Among WPC pilots that did not select IPU as a P4O metric, the same pattern of increase was observed in the Pre-WPC Years and WPC Year 1.

Exhibit 162: Unadjusted Rates of All-Cause Readmissions for PY 3 (2018) Enrollees by whether Pilot had Selected Metric as Pay for Outcome, Before and After WPC Enrollment



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Includes 329,332 WPC person-years with sufficient Medi-Cal enrollment and claims data. Rates are calculated based on first enrollment into WPC. Appendix B, Exhibit 11 provides details on which Pilots had Pay for Outcome arrangements. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Examining the ACR rates for all WPC enrollees after adjusting for enrollee and Pilot characteristics showed an increase in WPC Year 1 compared to Pre-WPC Years and a decline in WPC Year 2 (Appendix K, Exhibit 1). The highest observed rate of ACR in WPC Year 1 is likely because WPC is designed to enroll Medi-Cal beneficiaries with highest levels of utilization. The receipt of WPC services in WPC Year 1 is likely to have subsequently resulted in a reduction in ACR in WPC Year 2.

Comparison of Adjusted Trends in WPC Metrics Between WPC Enrollees and Control Group, Before and After WPC Enrollment

UCLA compared WPC metrics between WPC enrollees and a control group of Medi-Cal enrollees before and during WPC enrollment using the difference-in-difference (DD) methodology (Appendix A). The control group was selected using WPC enrollee demographics, health conditions, and service utilization. The baseline and WPC enrollment periods were constructed as described in the previous section. Each individual in the control group with similar characteristics as the WPC enrollee was examined for the same time periods.

To conduct the DD analyses, UCLA created a final analytic sample from a master dataset of over 4.6 million Medi-Cal enrollees who had either enrolled in WPC or met specific criteria consistent with Pilot target populations (Appendix A). The WPC enrollee and control group sample sizes and characteristics are shown in Appendix A and showed relatively similar proportions overall, with some differences in age, race/ethnicity, and primary language.

Two better health universal metrics could be calculated following DHCS metric-specifications, including 2.1: Ambulatory Care – Emergency Department Visits (AMB-ED) and 2.2: Inpatient Utilization – General Hospital/Acute Care (IPU). Detailed DD results can be found in Appendix K.

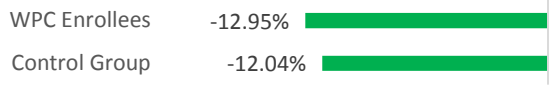
Assessment of differences in the universal metric values before (average of Pre-WPC Years) and after WPC (average of WPC Years) implementation did not indicate a significant change in AMB-ED rates for either WPC enrollees (0.62) or the control group (0.51) before and after WPC enrollment (DD: 0.12, Exhibit 163). However, assessing the change in AMB-ED rate from WPC Year 1 to WPC Year 2 indicated that this rate significantly decreased by 19% for WPC enrollees and 8% for the control group, a significantly larger decrease for the former (data not shown).

Assessing pre- and post-WPC differences in the rate of hospitalizations (IPU) showed that this rate increased for both the WPC enrollees (17.47) and the control group (7.41) from before to during WPC. The increase for WPC enrollees was significantly greater (DD: 10.06). Yet, examining the change from WPC Year 1 to WPC Year 2 showed a decrease of 4% for WPC enrollees and 33% for the control group, a significantly greater decrease for the latter (data not shown).

AMB-ED and IPU rates measure changes in the average number of visits and hospitalizations but do not clearly indicate changes in the likelihood of these events, which is an important and alternative way to assess the impact of WPC. Therefore, UCLA constructed two measures to show the proportion of people in the WPC population who ever had an ED visit or hospitalization. The likelihood of having any ED visit after enrolling in WPC declined significantly

among the WPC enrollees (-12.95%), as well as among the control group (-12.04%). The decrease for WPC enrollees was significantly greater than the control group (DD: -0.92%). Similarly, the rate of having any hospitalizations after enrolling in WPC decreased for both WPC enrollees and the control group. The decrease for WPC enrollees was significantly greater than the control group (DD: -1.48%). These measures showed that fewer WPC enrollees had ED visits or hospitalizations during enrollment in WPC than the control group during the same time period.

Exhibit 163: Difference-in-Difference Analyses of Universal and Alternative Metrics

WPC Universal Metrics		
2.1 – Ambulatory Care: Emergency Department (ED) Visits per 1,000 Medi-Cal Enrollees (AMB)	*WPC: N = 329,332* *Control: N = 644,836*	
		DD: 0.12
2.2 – Inpatient Utilization: Inpatient Admissions per 1,000 Medi-Cal Enrollees (IPU)	*WPC: N = 329,332* *Control: N = 644,836*	
		DD: 10.06*
Alternative Metric: Any ED Visit	*WPC: N = 329,332* *Control: N = 644,836*	
		DD: -0.92%*
Alternative Metric: Any Hospitalization	*WPC: N = 329,332* *Control: N = 644,836*	
		DD: -1.48%*

Not significant before and during WPC within each group (WPC Enrollees or Control Group), $p \geq 0.05$; Intended direction and significant before and during WPC within each group (WPC Enrollees or Control Group), $p < 0.05$; Unintended direction and significant before and during WPC within each group (WPC Enrollees or Control Group), $p < 0.05$

Source: UCLA analysis of Medi-Cal data, July to August 2019.

Notes: N: number of person-years analyzed per metric, DD: difference-in-difference. * Denotes $p < 0.05$ for difference-in-difference analysis

One variant metric could be calculated following DHCS metric-specifications, 3.1.1: All-Cause Readmissions (ACR). This metric was further analyzed for all WPC enrollees and those who were

enrolled in Pilots that chose to participate and report on this variant metric. Detailed DD results can be found in Appendix K.

The rate of ACR was calculated for all Pilots to show overall trends and for Pilots that selected to report on this variant metric. The overall ACR rate indicated a significant increase for WPC enrollees after enrollment (1.14%) but this rate did not change for the control group (-0.30%, Exhibit 164). The difference between the two groups was significant (DD: 1.44%). However, comparing the change in ACR rates from WPC Year 1 to WPC Year 2 showed that the overall ACR declined by 16% among WPC enrollees and 2% among the control group, a significantly larger decline for the former (data not shown).

Among Pilots that selected to report on this metric, the ACR rates after WPC did not change significantly for WPC enrollees (0.17%) or the control group (-0.36%, DD: 0.53%). When comparing the change from WPC Year 1 to WPC Year 2, a decrease of 20% for WPC enrollees and 3% for the control group was observed, a significantly larger decrease for the former group (data not shown).

Exhibit 164: Difference-in-Difference Analyses of Variant Metrics

WPC Variant Metrics	
3.1.1 – All-Cause Readmissions (ACR) - All Pilots	*WPC: N = 43,191* *Control: N = 66,319*
WPC Enrollees 1.14% Control Group -0.30%	DD: 1.44%*
3.1.1 – All-Cause Readmissions (ACR) – Pilots That Selected This Variant Metric	*WPC: N = 26,041* *Control: N = 35,793*
WPC Enrollees 0.17% Control Group -0.36%	DD: 0.53%

Not significant before and during WPC within each group (WPC Enrollees or Control Group), $p \geq 0.05$; Unintended direction and significant before and during WPC within each group (WPC Enrollees or Control Group), $p < 0.05$

Source: UCLA analysis of Medi-Cal data, July to August 2019.

Notes: N: number of person-years analyzed per metric, DD: difference-in-difference. * Denotes $p < 0.05$ for difference-in-difference analysis

Trends in WPC Pilot-Reported Metrics

Five variant metrics could not be replicated using Medi-Cal data. Therefore, UCLA calculated the weighted average values for these metrics (Exhibit 165). Some Pilots did not report metrics for reasons such as no enrollment or program activities during the reporting time period or lack of data in that time period. See Appendix B for further details on reporting for each metric, including which Pilots reported on each metric during each measurement year.

Pilot-reported metrics differ from those created based on Medi-Cal data for multiple reasons. Because these metrics were reported in the aggregate by each Pilot, they could not be reported for PY 2 and PY 3 enrollees separately. In addition, they were based on a different population of enrollees in each measurement year and were reported for a calendar year rather than years before and after WPC enrollment. Furthermore, Pilots reported one year of baseline and UCLA used two years of baseline. Pilots also reported baseline values based on Medi-Cal enrollment and used WPC enrollment for reporting years, while UCLA used Medi-Cal enrollment for all years.

Exhibit 165: Pilot-Reported Universal and Variant Metrics That Indicate Better Health

Universal vs. Variant	Metric Name and Number	Description	Baseline Year	Reporting Years	Numbers of Pilots Reporting by Year	Improvement Measured by Increase or Decrease
Variant	3.1.2: Decrease Jail Incarceration (DJI)	DJI: Incarcerations per 1,000 member months of enrollees 14 years of age and older	PY 1 (2016)	PY 2, PY 3	6 in PY 1 5 in PY 2 7 in PY 3	Decrease
Variant	3.1.3: Overall Beneficiary Health (OBH)	OBH-O: Self-reported rating for enrollees overall health	PY 2	PY 3	4 in PY 2 6 in PY 3	Increase
		OBH-E: Self-reported rating for enrollees mental or emotional health	PY 2	PY 3	4 in PY 2 5 in PY 3	Increase
Variant		CBP-18-59: Percent of enrollees 18-59 years of age whose	PY 1 (2016)	PY 2, PY 3	8 in PY 1 6 in PY 2	Increase

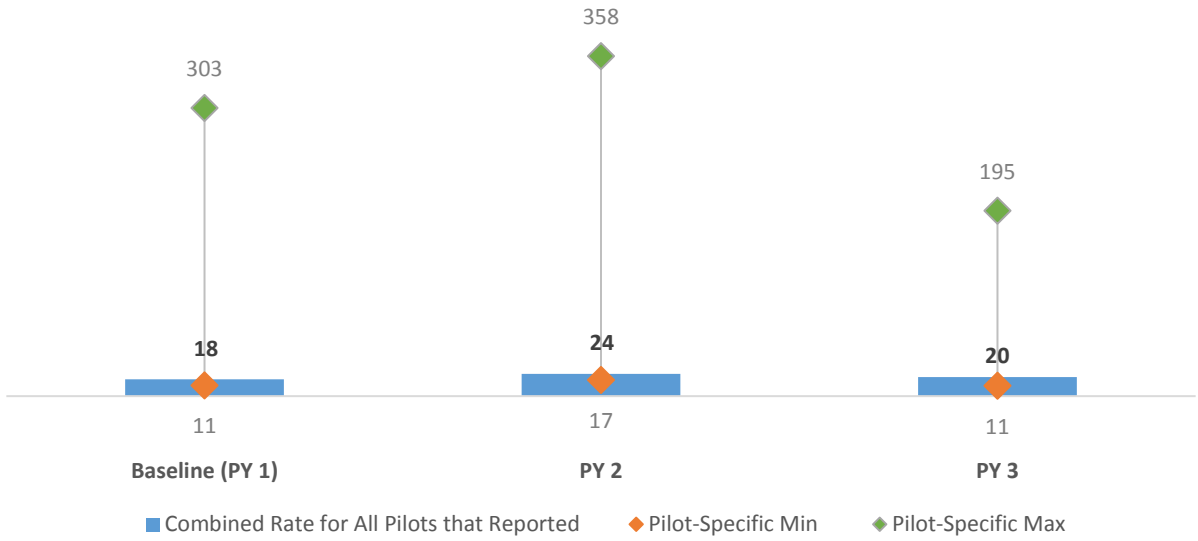
Universal vs. Variant	Metric Name and Number	Description	Baseline Year	Reporting Years	Numbers of Pilots Reporting by Year	Improvement Measured by Increase or Decrease
	3.1.4: Control Blood Pressure (CBP)	BP was <140/90 mmHg			7 in PY 3	
		CBP-60-85-D: Percent of enrollees 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mmHg	PY 1 (2016)	PY 2, PY 3	8 in PY 1 6 in PY 2 7 in PY 3	Increase
		CBP-60-85-ND: Percent of enrollees 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mmHg	PY 1 (2016)	PY 2, PY 3	8 in PY 1 6 in PY 2 7 in PY 3	Increase
Variant	3.1.5: Comprehensive Diabetes Care (CDC)	CDC: Percentage of enrollees 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8%)	PY 1 (2016)	PY 2, PY 3	11 in PY 1 11 in PY 2 11 in PY 3	Increase
Variant	3.1.6: PHQ 9/Depression Remission at 12 Months (NQF 0719)	NQF 0719: Percentage of enrollees 18 years of age and older with Major Depression or Dysthymia who reached remission 12 months (+/- 30 days) after an index visit	PY 1 (2016)	PY 2, PY 3	9 in PY 1 9 in PY 2 11 in PY 3	Increase

Source: PY 1 (baseline), PY 2, and PY 3 Annual WPC Variant and Universal Metric Reports and Whole Person Care Universal and Variant Metrics Technical Specifications (March 22, 2019).
Note: BP is blood pressure.

Variant Metric 3.1.2: Decrease Jail Incarcerations (DJI)

Seven WPC Pilots elected to report the number of incarcerations that occurred per 1,000 member months for those ages 14 or older as of December 31 of the measurement year (DJI). The overall DJI rate increased from 18 incarcerations per 1,000 member months during baseline to 24 in PY 2, but declined to 20 in PY 3 (Exhibit 166). There was variation in DJI by Pilot, for example, ranging from a low of 11 in PY 1 to a high of 358 in PY 2. One large Pilot accounted for between 72% and 83% of the denominator each year for this metric and this Pilot reported the lowest DJI rate among all Pilots each year. Without this influential Pilot, the DJI rate remained steady from baseline to PY 2 at 48 and declined in PY 3 to 44 (data not shown).

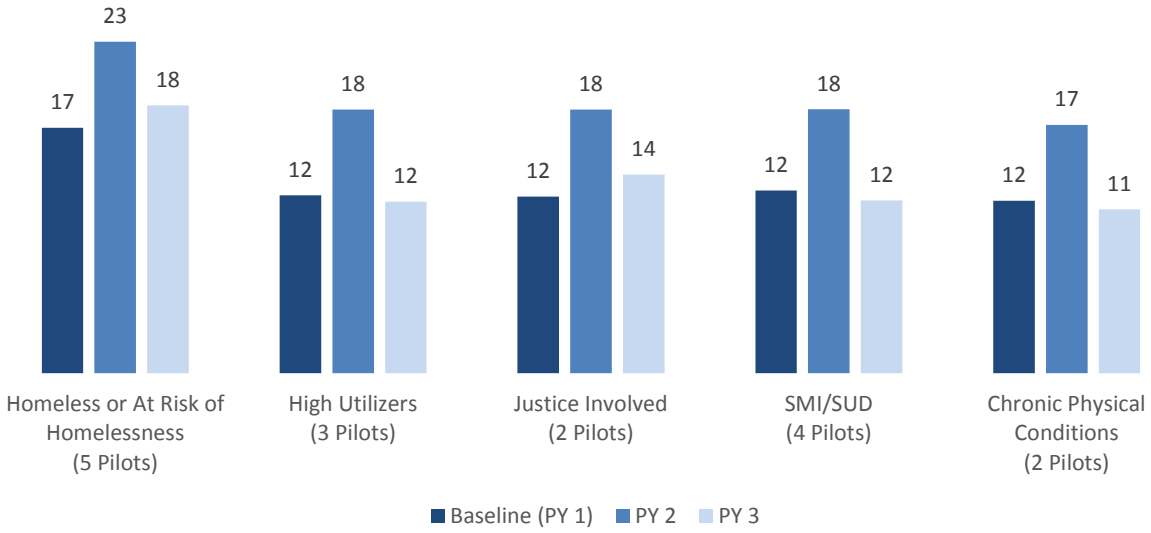
Exhibit 166: Number of Incarcerations per 1,000 WPC Member Months, by Program Year



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 2 provides details on which Pilots reported in each year. The denominator size is shown as sample size per year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot.

Examining the DJI rate by grouping Pilots that selected a target population showed that rates remained steady from baseline to PY 3 among Pilots that selected any target populations other than justice-involved (Exhibit 167). Notably, among Pilots that selected justice-involved, the rate increased from 12 to 14 incarcerations per 1,000 member months from baseline to PY 3. During PY 2, the rate peaked among all Pilot groups.

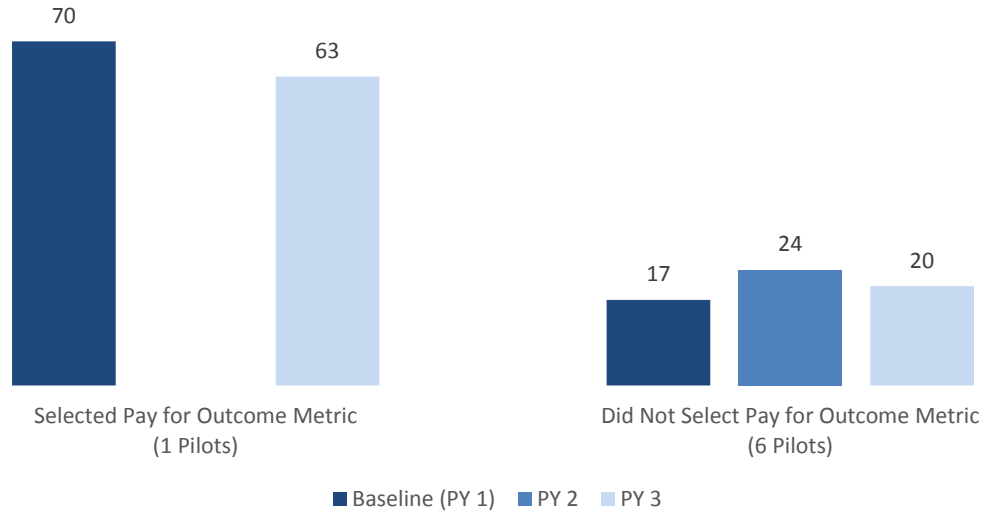
Exhibit 167: Number of Incarcerations per 1,000 Member Months, Among Pilots That Selected Specific Primary Target Populations



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Data indicated rates among Pilots that selected a given target population and do not reflect rates among enrollees in a target population. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 2 provides details on which Pilots reported in each year. Pilots can have multiple primary target populations, and thus the primary target population groups are not mutually exclusive. SMI/SUD is severe mental illness and/or substance use disorder.

Of the seven Pilots that reported on this metric, one had a P4O incentive to reduce incarceration rates by 10% per year. This Pilot reduced their DJI rate from 70 to 63 incarcerations per 1,000 member months from baseline to PY 3 (Exhibit 168). Due to a denominator less than 11, DJI could not be reported during PY 2 for the Pilot with a P4O. During the same time period, Pilots without a P4O reported an increased in DJI.

Exhibit 168: Number of Incarcerations per 1,000 Member Months, by Whether Pilot Had Selected Pay for Outcome Incentives

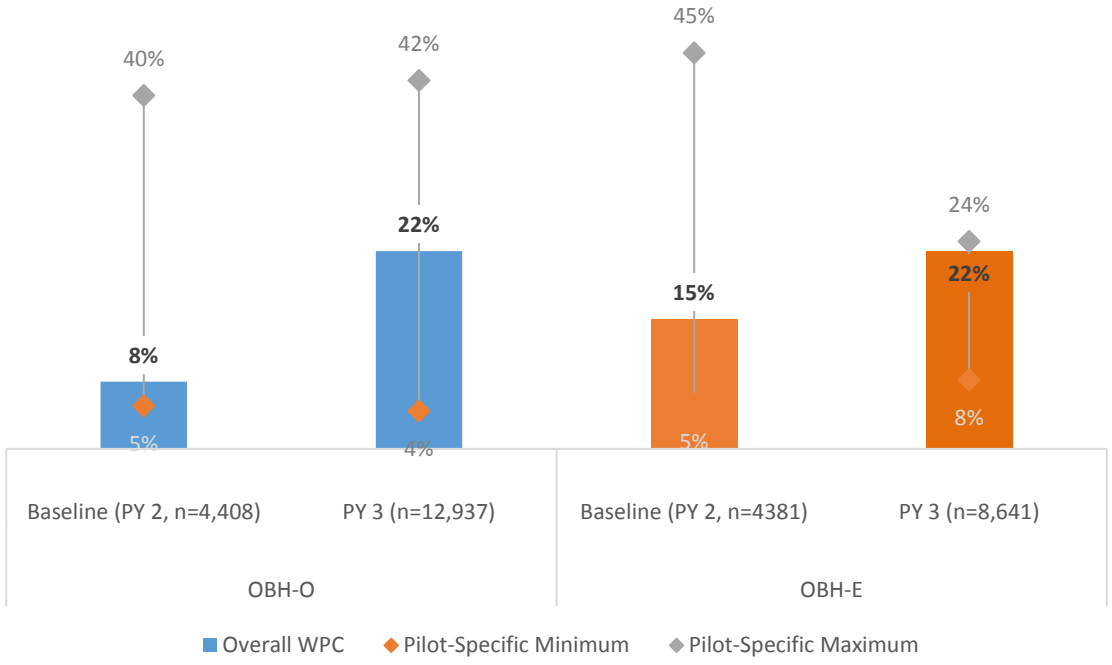


Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 2 provides details on which Pilots reported in each year. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered. Missing measurement year was due to lack of data or denominators less than 11.

Variant Metric 3.1.3: Overall Beneficiary Health

Six WPC Pilots elected to report the percent of enrollees reporting "Excellent" or "Very Good" overall health (OBH-O) and the percent of enrollees reporting "Excellent" or "Very Good" emotional health (OBH-E). Overall OBH-O increased from 8% during baseline to 22% in PY 3 (Exhibit 169). Overall OBH-E also increased from 15% during baseline to 22% in PY 3. There was variation by Pilot in percent reporting good health, ranging from a low of 5% for overall and emotional health during baseline to a high of 45% for emotional health during baseline. One large Pilot accounted for between 60% and 90% of the denominators for this metric. However, their rates were aligned with other Pilots reporting and did not largely influence the overall rates.

Exhibit 169: Percent of Enrollees Who Reported "Excellent" or "Very Good" Overall Health (OBH-O) and Emotional Health (OBH-E), by Year



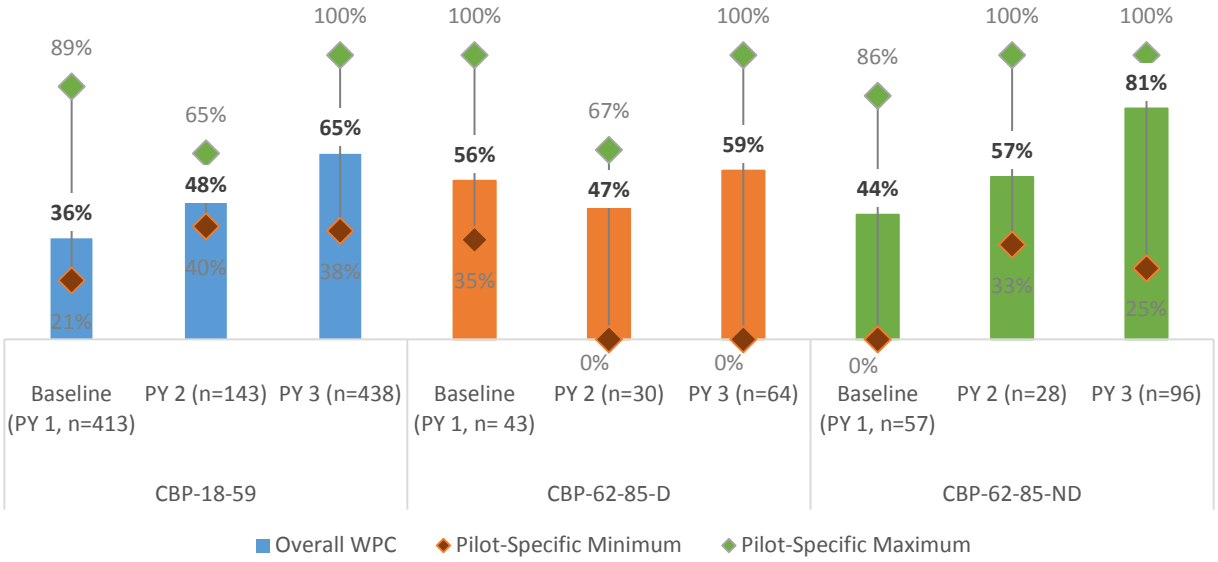
Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 3 provides details on which Pilots reported in each year. The denominator size is shown as sample size per year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot.

Data based on grouping of Pilots that selected specific target populations or Pilots that selected P4O incentives were sparse and were not presented.

Variant Metric 3.1.4: Controlling High Blood Pressure

Eight WPC Pilots elected to report on the percent of three groups (individuals age 18-59, individuals age 60-85 with diabetes, individuals age 60-85 without diabetes) of enrollees whose blood pressure was adequately controlled during the measurement year. The blood pressure control rate for all three groups, increased from bsaeline to PY 3 (Exhibit 170). There was variation by Pilot in the percent of enrollees who had controlled blood pressure in all measurement years. Many Pilots had denominators less than 11 during all measurement year, resulting in substantial variation in the rates by Pilots.

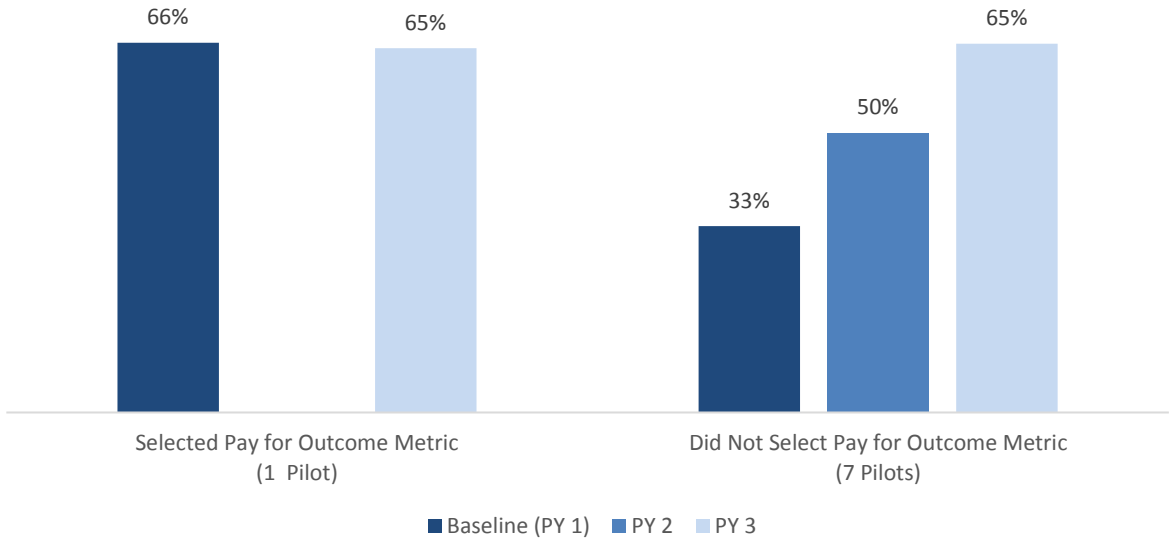
Exhibit 170: Percent of WPC Enrollees with Controlled Blood Pressure, by Program Year



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 1 provides details on which Pilots reported in each year. The denominator size is shown as sample size per year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot. A rate of 0% indicates that no enrollee had adequately controlled blood pressure during the measurement year. Controlled blood pressure was defined as less than 140/90 mmHg for those age 18 to 59 (CBP-18-59), less than 140/90 mmHg for those age 60 to 85 with a diagnosis of diabetes (CBP-60-85-D), and less than 150/90 mmHg for those age 60 to 85 without a diagnosis of diabetes (CBP-60-85-ND).

Due to sparse data, an analysis by Pilots that selected particular target populations was not included. Of the eight Pilots that reported on CBP-18-59, one had a P4O incentive to improve by 5% per year. While Pilots without a P4O reported improvements in this metric from baseline to PY 3, the Pilot with a P4O did not (Exhibit 171), however the overall rates in this group were higher.

Exhibit 171: Percent of Enrollees Age 18 to 59 With Controlled Blood Pressure, by Whether Pilot Had Selected Pay for Outcome Incentives

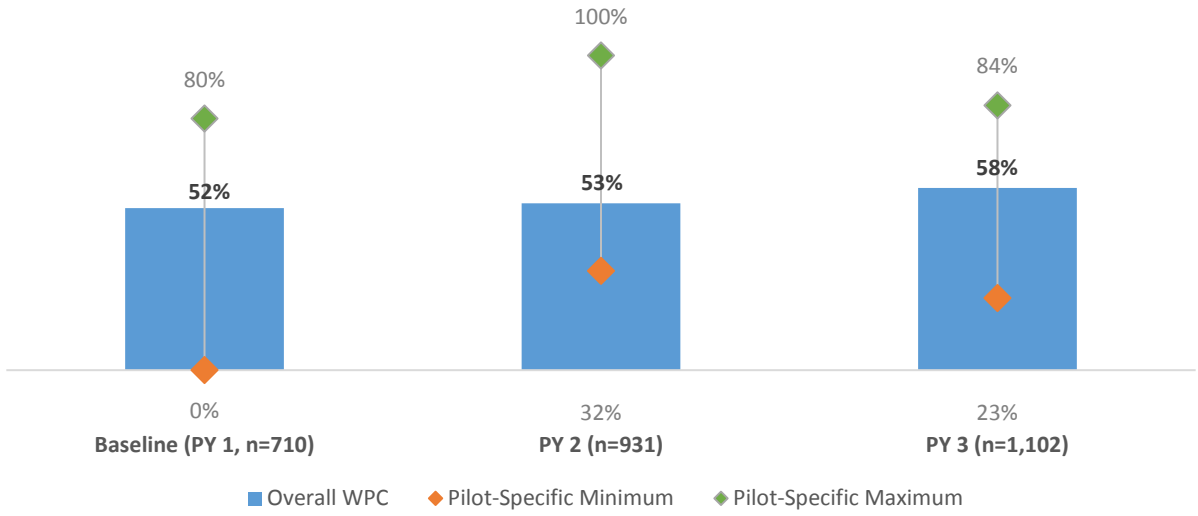


Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 1 provides details on which Pilots reported in each year. Missing data is due to small sample size. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered. Missing measurement year was due to lack of data or denominators less than 11.

Variant Metric 3.1.5: Comprehensive Diabetes Care (CDC)

Eleven WPC Pilots elected to report the percent of enrollees age 18 to 17 with either Type 1 or Type 2 diabetes, who had controlled Hemoglobin A1c (HbA1c), with a value of less than 8% (CDC). The overall CDC rate increased from 52% in baseline, to 53% in PY 2, to 58% in PY 3 (Exhibit 172). There was variation by Pilot, ranging from a low of 0% in baseline to a high of 100% in PY 2.

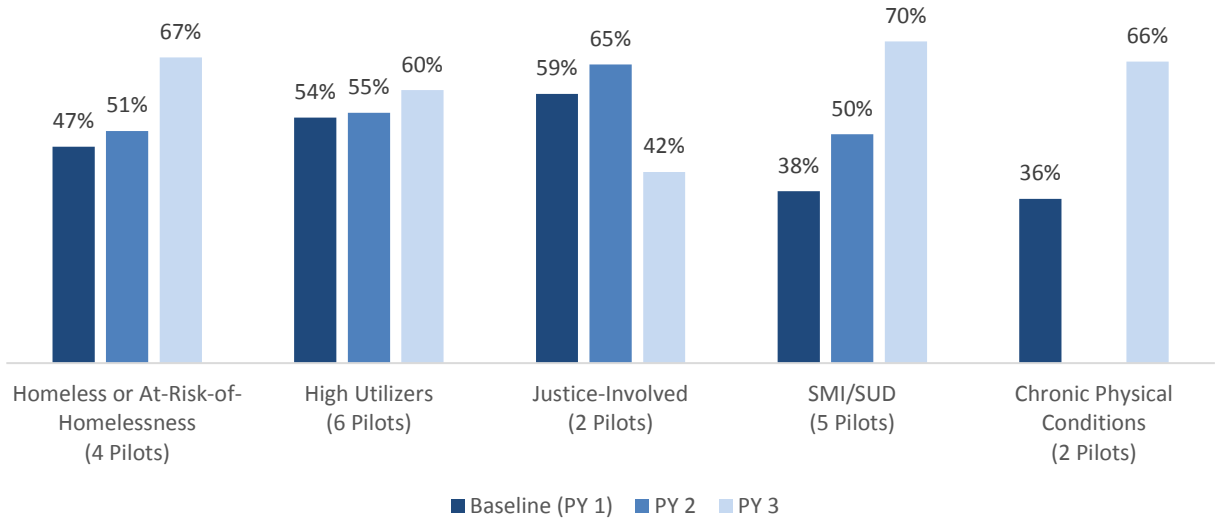
Exhibit 172: Percent of Adult Enrollees with Diabetes Who Had Controlled HbA1c, by Program Year



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 5 provides details on which Pilots reported in each year. The denominator size is shown as sample size per year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot. A rate of 0% indicated that no enrollees had controlled HbA1c scores in the measurement year.

Examining the CDC rate by grouping Pilots that selected a target population showed mixed trends (Exhibit 173). Among Pilots that selected homeless or at-risk-of-homelessness, high utilizers, SMI/SUD and chronic physical conditions target groups, the CDC rate increased from baseline to PY 3. In contrast, Pilots that selected justice-involved target population reported a decrease from 59% to 42%. Rates peaked among Pilots that selected justice-involved as a target population during PY 2.

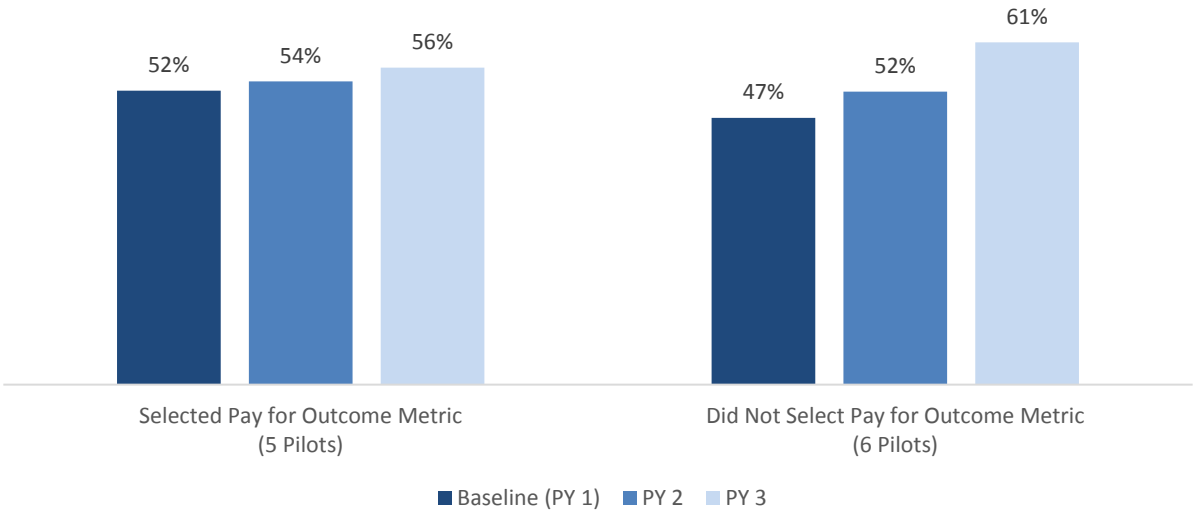
Exhibit 173: Percent of Adult Enrollees with Diabetes Who Had Controlled HbA1c, by Pilot Primary Target Population(s)



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Notes: Data indicated rates among Pilots that selected a given target population and do not reflect rates among enrollees in a target population. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 5 provides details on which Pilots reported in each year. Pilots can have multiple primary target populations, and thus the primary target population groups are not mutually exclusive. SMI/SUD is severe mental illness and/or substance use disorder. Missing measurement year was due to lack of data or denominators less than eleven.

Of the 11 Pilots that reported on this metric, five had P4O incentives for similar performance measures. Pilots with and without a P4O reported similar trends in CDC rates (Exhibit 174), with rates increasing from baseline to PY 3.

Exhibit 174: Percent of Adult Enrollees with Diabetes Who Had Controlled HbA1c, by Whether Pilot Had Selected Pay for Outcome Incentives

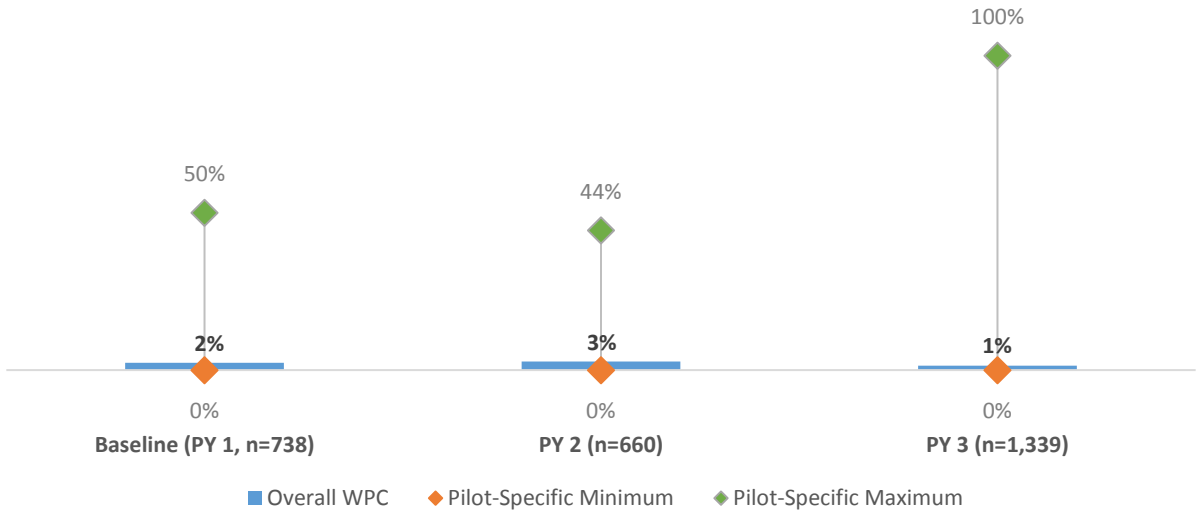


Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Note: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 5 provides details on which Pilots reported in each year. Pilots had pay for outcome incentives based on universal or variant metrics, but in some cases, metric specifications were slightly altered.

Variant Metric 3.1.6: PHQ-9/Depression Remission at 12 Months (NQF 0719)

Eleven WPC Pilots elected to report the percent of enrollees age 18 or older with major depression or dysthymia who reached remission measured at 12 months, plus or minus 30 days, after an index visit (NQF 0719). The overall NQF 0719 rate remained low for all three years, at 3% or less (Exhibit 175). There was variation by Pilot, ranging from a low of 0% in all measurement years to a high of 100% in PY 3. One large Pilot accounted for 82% of enrollees in this metric. Yet, without this Pilot the data was too sparse to report.

Exhibit 175: Percent of Enrollees Age 18 or Older with Major Depression or Dysthymia Who Reached Remission at 12 Months, by Program Year



Source: PY 1 (Baseline), PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports
Note: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 6 provides details on which Pilots reported in each year. The denominator size is shown as sample size per year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot. A rate of 0% indicated that no enrollees reached remission in the timeframe.

Due to sparse data, UCLA was unable to analyze NQF 0719 by Pilot's primary target populations or by P4O.

Chapter 13: Homeless WPC Enrollee Services and Outcomes

All 25 WPC Pilots provided housing and supportive services to enrollees. This chapter addresses the following evaluation question: "To what extent did the pilot increase access to housing and supportive services and improve housing stability, if applicable?" In addition to addressing this question, this chapter included data on characteristics of homeless enrollees and Pilot-reported metrics relevant to this population.

Data sources for this chapter included interim Pilot surveys and follow-up interviews with leadership and frontline staff of all 27 Pilots, as well as interim partner surveys with 227 partner organizations. Additional qualitative data around challenges and solutions was provided in 25 WPC mid-year and annual narrative reports. Homeless enrollee characteristics and housing outcomes came from enrollment and utilization reports from 25 Pilots and Medi-Cal enrollment and claims data. For additional detail on data sources and methodology please see the Analytic Methods.

Approaches to Enrollment in and Delivery of Housing Services to Homeless and At-Risk-Of-Homelessness Populations

Fifteen Pilots chose homeless as their primary target population, though all others may have provided WPC services to homeless populations. Nine Pilots chose at-risk-of-homelessness as their primary target population in addition to homeless. Monterey and San Francisco only focused on homeless individuals as their target population, while Napa primarily focused on homeless and at-risk-of-homelessness populations. Pilots typically used the Department of Housing and Urban Development's (HUD) criteria to identify individuals as homeless or at-risk-of-homelessness.

In interim surveys, Pilots were asked about the extent to which WPC goals and components fit with their organizations' strategic priorities on a scale of zero (very low) to ten (very high). On average, Pilots rated increasing client/patient access to housing and supportive services (e.g., housing navigation, tenancy support) relatively high (8.7 of 10), indicating housing homeless enrollees as a relatively high priority for Pilots (data not shown).

Outreach to the Homeless Population

In follow-up interviews and narrative reports, Pilots discussed variations in their approach to engaging with and maintaining communication with homeless populations. Pilots highlighted

that significant challenges of outreach and enrollment of homeless populations were outdated or unavailable contact information and reluctance of those eligible for WPC to enroll because of past negative experiences.

Therefore, successful approaches included in-person communication with homeless through visits to homeless shelters or other areas where homeless populations gathered such as encampments and scheduling follow-up meetings. Several Pilots noted that efforts to locate homeless individuals often required coordination with local organizations such as shelters, churches, and police departments. These efforts were key to outreach and building rapport with homeless enrollees to enroll and retain them in WPC. Examples of homeless outreach and engagement activities are provided in Exhibit 176. Data showed that Pilots focused on constructing multidisciplinary outreach teams that included mental health and substance use disorder professionals and peers with lived experience, placing outreach workers in shelters or other sites frequented by the homeless.

Exhibit 176: Selected Examples of Outreach Approaches to Homeless Populations in WPC

Outreach Approaches	WPC Pilot	Selected Examples
Homeless Outreach Teams	Alameda	Alameda aimed to reduce barriers to health care through a proactive approach with their "StreetHealth" program, a street psychiatry outreach program comprised of a psychiatrist, a nurse case manager, and a community outreach worker. "StreetHealth" conducted psychiatric evaluations and administered medication and SUD treatment to individuals in homeless encampments in downtown Oakland.
	Napa	Napa initiated contact with eligible enrollees through their homeless outreach teams, through a contracted service provider and in partnership with the Napa Police Department. Outreach teams identified and engaged unsheltered and sheltered homeless populations. Outreach teams performed initial intake assessments, enrolled individuals, and entered them into the county's coordinated entry system.
	Riverside	Riverside's homeless outreach teams were responsible for connecting homeless individuals to social support services and acquiring basic documentation needed to apply for Medi-Cal, and subsequently enroll into WPC. Riverside also had WPC Housing Navigators in the coordinated entry system to help with housing access for WPC enrollees.
	Kings	Kings conducted weekly visits at a church that served food to the underserved and homeless to engage eligible enrollees.
	San Francisco	San Francisco conducted street and shelter-based outreach to initiate contact with eligible enrollees. Care coordinators were expected to contact enrollees weekly, noting that continued in-person communication was key to engaging with homeless enrollees and building rapport.

Outreach Approaches	WPC Pilot	Selected Examples
Dedicated staff roles	Contra Costa	Contra Costa had a homeless services specialist working directly in homeless shelters and with homeless patients to help enrollees apply for housing and connect them to additional service providers (e.g., mental health specialists, social workers) depending on their needs.
	Sacramento	Sacramento Covered community health workers (CHWs) and Sacramento housing specialists helped enrollees secure housing choice vouchers (HCV) by developing an expedited process to prepare, finalize, and submit HCV applications.
Efforts with local organizations to locate enrollees	Santa Cruz	Meeting homeless individuals at where they commonly congregated was one of Santa Cruz's outreach strategies to homeless individuals. Locations included a soup kitchen, Santa Cruz' Homeless Persons' Health Project, and their public library.
	Shasta	Shasta had their team locate WPC beneficiaries based on referrals and an outreach worker worked with local police in homeless camps to identify eligible enrollees.
Other	San Joaquin	San Joaquin noted challenges in engaging prospective homeless enrollees due to their transient nature and some hesitation to engage in services. To build rapport with homeless enrollees, San Joaquin addressed immediate needs (e.g., food, shower, clean clothes) before addressing more difficult topics. While these activities were not funded by WPC, San Joaquin sought out partnerships to address these enrollee needs.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019 and Whole Person Care Program Mid-Year and Annual Narrative Reports (n=25), January 2017-March 2019.

Tracking and Retention

Given the transient nature of the population and difficulty in maintaining contact post WPC enrollment, some Pilots used a homeless data system to track and retain enrollees who were homeless or at-risk-of homelessness. Many Pilots began tracking enrollees in Homeless Management Information Systems (HMIS) immediately upon enrollment. For example, some Pilots tracked enrollees' risk of homelessness, income, and disabilities to better deliver the necessary services. In addition, Pilots also used these systems to track whether patients received services and obtained housing.

Tracking required collaboration with partners. In interim surveys, Pilots reported on the degree of buy-in for data sharing among partners on a scale of zero (very low) to ten (very high). Out of all categories of partners (e.g., health plans, hospitals, mental health providers), housing providers had the highest buy-in at 7.7 of 10 (data not shown).

Examples of approaches to tracking homeless enrollees and outcomes of service delivery are provided in Exhibit 177, based on follow-up interviews.

Exhibit 177: Selected Examples of Approaches to Tracking, Retention, and Measuring Outcomes of Homeless Enrollees in WPC

Approaches to Tracking and Retention of Homeless Enrollees	WPC Pilot	Selected Examples
Tracking and retention	Alameda	Alameda launched their Homeless Management Information Systems (HMIS) through a collaboration with many stakeholders, including: Alameda's Housing and Community Development department, the Continuum of Care staff, and multiple homeless/housing service providers. The system was used by 46 agencies to prioritize clients for supportive housing and track outcomes. The regional Housing Resource Centers used HMIS data to connect homeless individuals to healthcare and other support services.
	Kings	Kings employed a housing navigator to utilize HMIS to assess risk of homelessness among enrollees, facilitate appropriate linkage and referrals, and provide the necessary services for enrollees. Kings also used HMIS to track progress and decrease duplication of services.
	Shasta	All enrollees were enrolled in HMIS to track income, disabilities, housing status, and if they were chronically homeless.
	Sonoma	Sonoma's Department of Health Services and Behavioral Health staff partnered with the county's community development commission to become an access point for enrollees to join the county's coordinated entry system. Access to HMIS allowed staff to view previous assessments and program enrollment status, submit new and updated assessments, identify where clients were at on the housing lists and support expediting services for high need, high risk clients.
Measuring outcomes	Placer	Placer tracked changes in enrollees' living situations (e.g., incarceration, homelessness, or transition into permanent housing). Metrics were used to track enrollees who successfully transitioned into permanent housing since enrolling in the Pilot.
	Sacramento	Pathways community health workers (CHWs) documented when an enrollee was referred to housing services in the Shared Care Plan (SCP) portal and tracked subsequent housing services. Sacramento also required Pathways housing providers to track homeless enrollees who were continuously housed for six months.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019 and Whole Person Care Program Mid-Year and Annual Narrative Reports (n=25), January 2017-March 2019.

Specialized Housing Staff in Care Coordination Teams

To improve delivery of WPC services to homeless enrollees, 17 of 27 Pilots reported including specialized housing staff to coordinate housing and supportive services in follow-up interviews. These staff included housing navigators and housing specialists. Pilots indicated that including a dedicated housing staff as part of a multi-disciplinary care coordination team and including someone with lived experience in particular was essential in effective delivery of care to

homeless enrollees. Selected examples of specialized housing staff in WPC are provided in Exhibit 178.

Exhibit 178: Selected Examples of Approaches to Inclusion of Specialized Housing Staff in WPC

Approaches to Inclusion of Specialized Housing Staff	WPC Pilot	Selected Examples
Housing coordinator/navigator with lived experience	Alameda	Alameda sought to improve enrollee engagement by hiring housing coordinators with similar lived experiences to that of WPC target populations. Housing coordinators were responsible for providing housing-related service bundles. Alameda also required its multidisciplinary care coordination teams to participate in two-hour, bi-weekly case conferencing meetings to ensure accountability.
	Contra Costa	Care coordinators provided housing and tenancy support services to enrollees and had similar lived experiences to that of WPC target populations. Contra Costa also had a homeless services specialist work with homeless individuals in homeless shelters.
	Marin	Marin had housing care coordinators with lived experiences similar to that of the WPC target population. Enrollees also received support from housing support specialists within WPC partner organizations.
	Mariposa (SCWPCC)	Mariposa had multi-disciplinary teams comprised of a housing navigation team with lived experience similar to that of WPC enrollees.
Other housing staff	Sacramento	Sacramento's multidisciplinary teams had housing service providers who specialized in housing support and housing care coordinators to make and monitor referrals into various housing programs.
	Shasta	Shasta's multidisciplinary teams comprised of a housing case manager who provided social work and benefits support.
	San Mateo	San Mateo established a housing committee to receive referrals, make recommendations, and prioritize beneficiaries eligible for housing subsidies paid for by county funding.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019 and Whole Person Care Program Mid-Year and Annual Narrative Reports (n=25), January 2017-March 2019.
Notes: SCWPCC is the Small County Whole Person Care Collaborative.

Leveraging Other Funding Sources

In follow-up interviews and narrative reports, Pilots provided information on how they leveraged other funding sources within the county to pay for rent and other costs that were not eligible expenditures under WPC. Fifteen of 27 used their flexible housing subsidy pools housing funds to provide financial assistance to individuals facing challenges in accepting or maintaining placement for housing. Some Pilots used other funding sources for other needed services

including federal and other grants. Examples of these approaches to leveraging additional funding sources for housing are shown in Exhibit 179.

Exhibit 179: Selected Examples of Approaches to Leveraging Alternative Funding Sources for Housing of WPC Homeless Enrollees

Approaches to Leveraging Alternative Funds	WPC Pilot	Selected Examples
Flexible Housing Pool	Alameda	Alameda utilized its Flexible Housing Subsidy Pool to obtain commitments from developers to make new housing units available. Alameda also allocated $1 million of its $5 million flexible housing pool to support their partnership with the Alameda Health System (AHS) in housing homeless AHS clients in acute and post-acute care settings.
	Los Angeles	Los Angeles formed a flexible housing pool including $20 million from LA Care Health Plan and over $40 million from the Los Angeles Department of Health Services. The flexible housing pool compiled funds to be used for rental assistance and subsidies for supportive housing. Los Angeles also contracted over 100 intensive case management service providers to provide services to enrollees accessing the pool.
	Napa	Napa worked with Abode Services to launch their Flexible Housing Pool. The partnership resulted in a centralized mechanism to better allocate funding resources to match enrollees' needs and to convince landlords to rent to vulnerable populations. Abode Services provided Napa with services in landlord negotiations, housing navigation, housing stabilization, and landlord liaison services. Napa also received contributions for its Flexible Housing Pool from Queen of the Valley and Partnership Health.
Other funding	Mariposa (SCWPCC)	Mariposa (Small County Collaborative) assisted enrollees at-risk-of-homelessness by obtaining funding (e.g., nonprofits) to pay for property fixes, allowing enrollees to stay in their homes. Home modifications included adding ramps for enrollees with mobility challenges and repairing leaking roofs.
	Monterey	Monterey planned to make 60 one-bedroom apartments available to WPC enrollees through two place-based voucher housing developments. Monterey also applied for federal grants to help create a 100-bed, year-round emergency shelter and a shelter for single adults.
	Placer	Placer began providing rental subsidies to clients, worked on a proposal to provide additional supportive housing services, and purchased housing with a $1 million grant from Sutter Health. Placer also rented space at local homeless shelters to provide more direct services to enrollees.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019 and Whole Person Care Program Mid-Year and Annual Narrative Reports (n=25), January 2017-March 2019.
Notes: SCWPCC is the Small County Whole Person Care Collaborative.

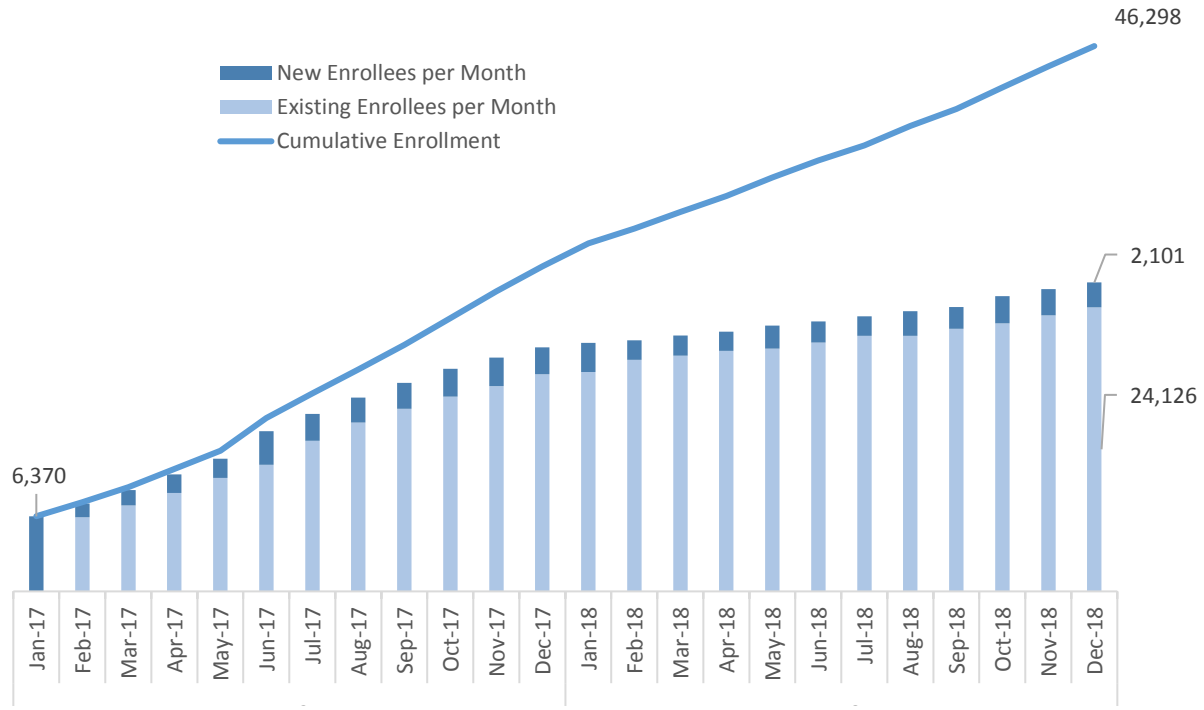
Enrollment Patterns and Demographics among Homeless WPC Enrollees

Under WPC, Pilots were required to identify homeless enrollees in their quarterly *WPC Enrollment and Utilization Reports*, regardless of whether or not they were a target population. UCLA used the homeless indicator to provide a profile of homeless enrollees. Of the 108,667 enrollees in WPC, 46,298 or 43% were identified as homeless using this homeless indicator. However, some Pilots reported difficulties in obtaining this data and therefore the number of homeless enrollees may be under reported.

Enrollment Size and Patterns among Homeless WPC Enrollees

Exhibit 180 shows the unduplicated enrollment of homeless WPC enrollees by month. From January 2017 through December 2018, the cumulative enrollment of homeless enrollees increased from 6,370 to 46,298, respectively. Total currently enrolled as of December 2018 was 26,227. The rate of monthly new homeless enrollment in WPC nearly doubled over this time period. The average monthly new homeless enrollment was 2,168 (data not shown).

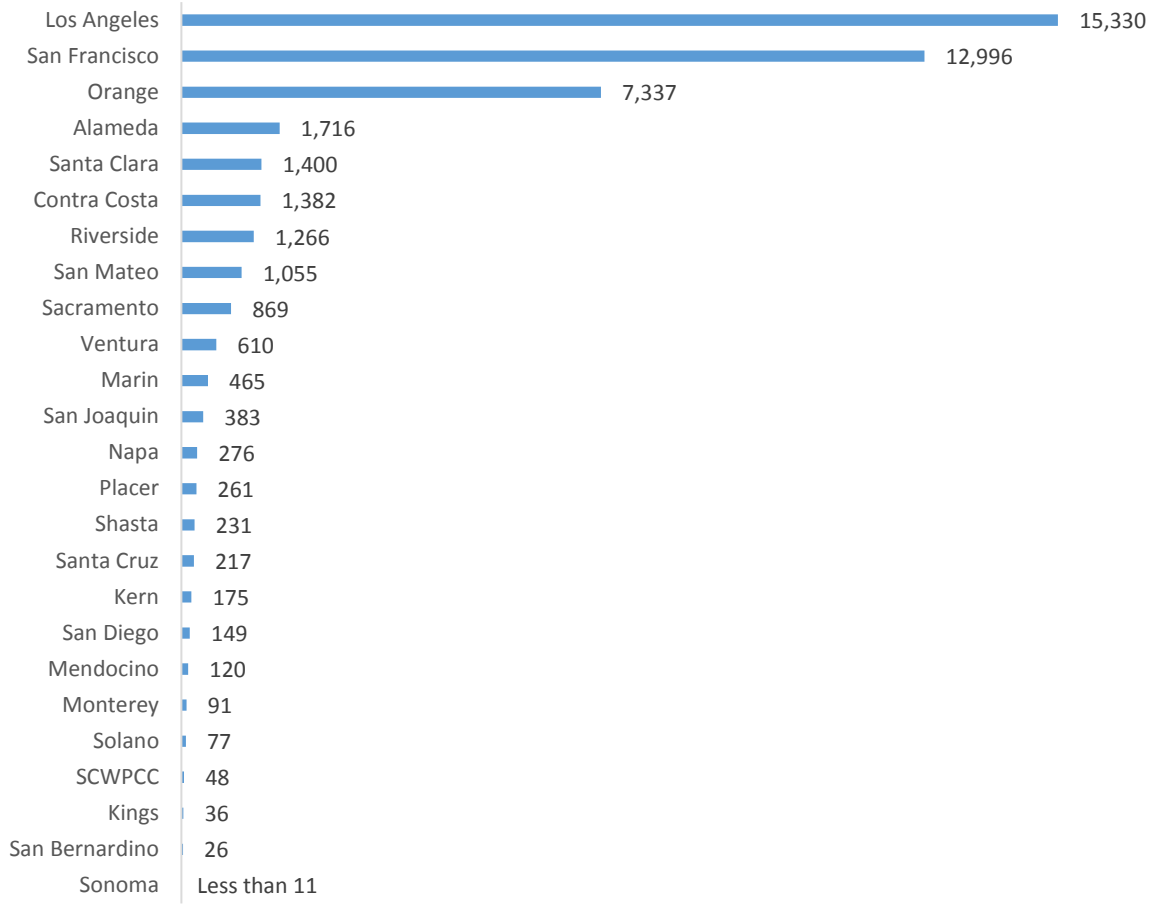
Exhibit 180: Unduplicated Monthly and Cumulative Total WPC Enrollment among Enrollees Identified as Homeless, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports* (n=25), January 2017-December 2018.
Notes: Includes 46,298 unique individuals. Excludes individuals who received outreach or other WPC services but did not enroll.

Exhibit 181 shows the total, unduplicated WPC homeless enrollment through PY 3 by Pilot, indicating a low of less than 11 enrollees in Sonoma and a high of 15,330 enrollees in Los Angeles. Eight Pilots had rates over 1,000, 11 had rates over 100, and six had rates under 100.

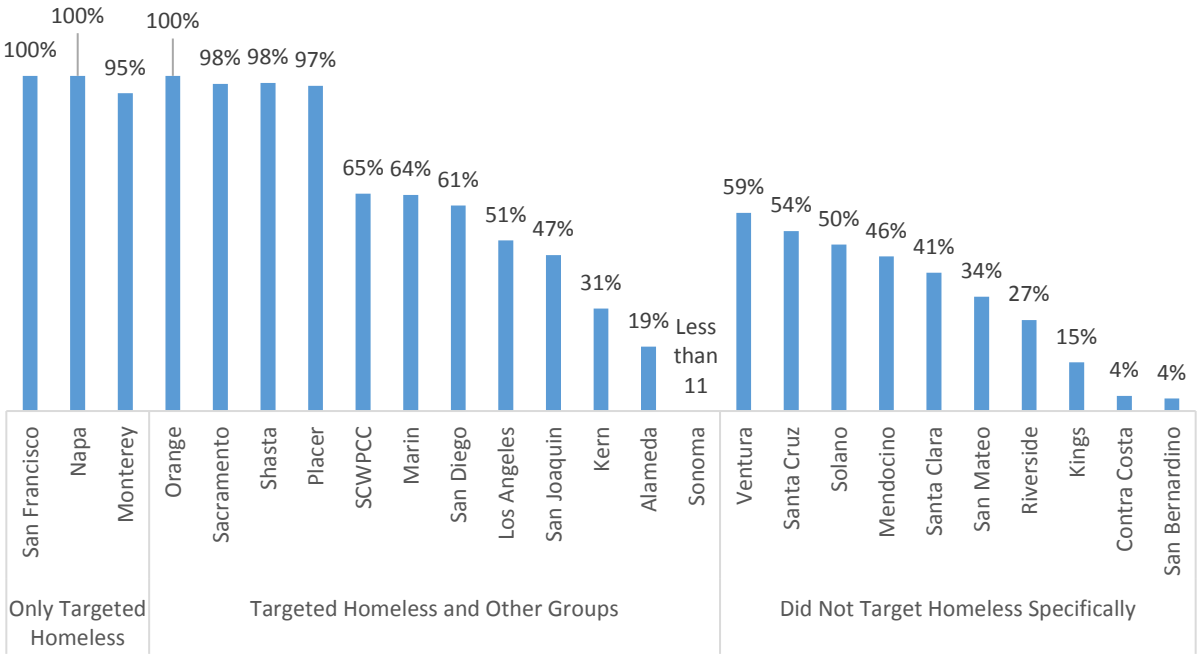
Exhibit 181: Total Unduplicated Enrollment in WPC by Pilot among Homeless Enrollees, December 2018



Source: *Whole Person Care Enrollment and Utilization Reports* (n=25), January 2017-December 2018.
Notes: Includes 46,298 unique individuals. SCWPCC is the Small County Whole Person Care Collaborative.

Exhibit 182 shows the percent of total WPC enrollees that were identified as homeless by Pilot. Pilots with only homeless or at-risk-of-homelessness as their only primary target population ranged from a high of 100% of WPC enrollees identified as homeless (San Francisco) to a low of 95% (Monterey). Pilots with homeless as a primary target population in addition to other groups ranged from a high of 100% (Orange) to a low of less than 11 (Sonoma). Pilots that did not list homeless as a primary target population ranged from a high of 59% (Ventura) to a low of 4% (Contra Costa, San Bernardino).

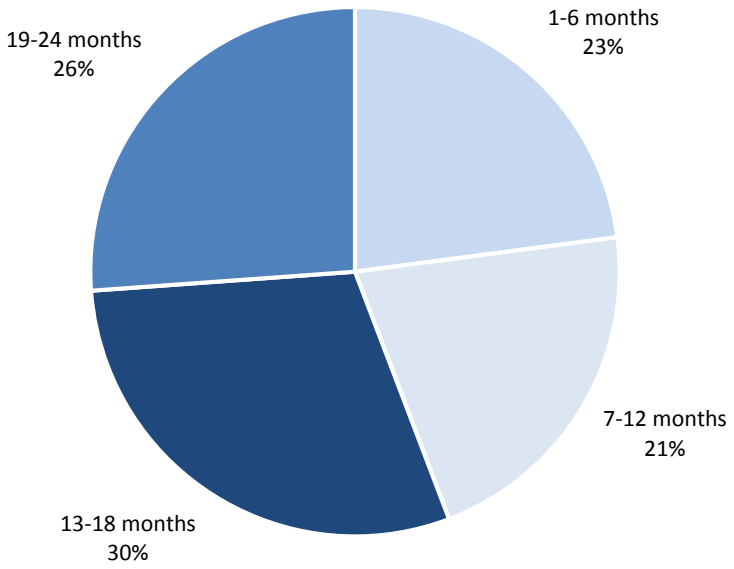
Exhibit 182: Percent of WPC Enrollees Identified as Homeless by Pilot, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports* (n=25), January 2017-December 2018.
Notes: Includes 46,298 unique individuals. SCWPCC is the Small County Whole Person Care Collaborative. Pilots that targeted homeless included pilots targeting at-risk-of-homelessness. While Monterey reported only 95% of their population as homeless using the homeless indicator in their *Enrollment and Utilization Reports,* 100% of their population was in the homeless target population.

Exhibit 183 displays the length of enrollment among WPC homeless enrollees for PY 2 and PY 3. A bigger proportion of homeless enrollees were enrolled for 13-18 months (30%) and fewer were enrolled for 7-12 months (21%). The average, median, and mode length of enrollment in the program was 13, 14, and 24 months, respectively (data not shown).

Exhibit 183: Length of Enrollment in WPC among Homeless Enrollees, January 2017 to December 2018

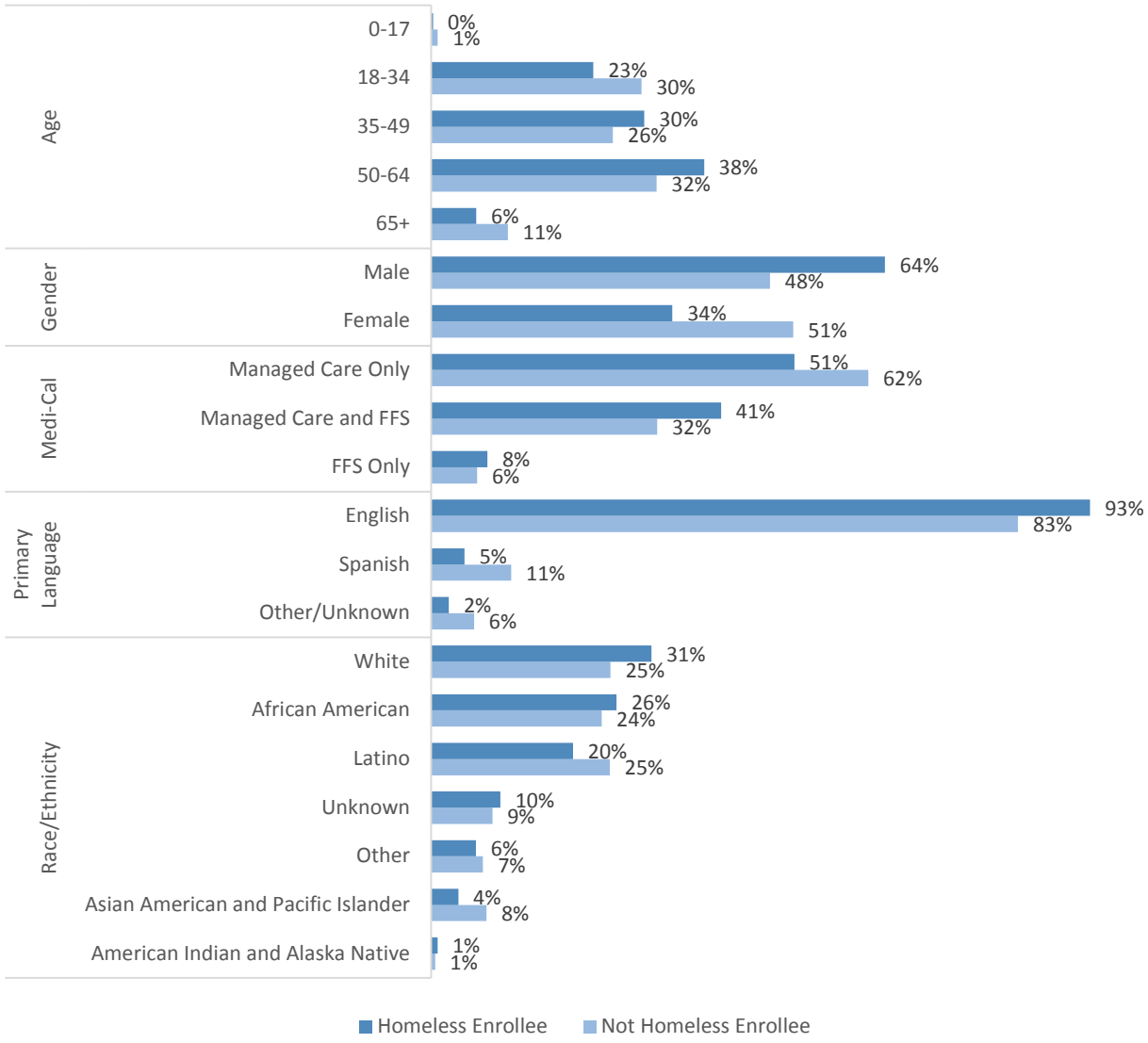


Source: *Whole Person Care Enrollment and Utilization Reports* (n=25), January 2017-December 2018.
Notes: Includes 108,913 unique enrollees by WPC Pilots (among 108,667 unique individuals). Includes 246 enrollees who enrolled at two Pilots without cross enrollment. Does not include re-enrollments. Excludes 156 enrollees that were cross-enrolled at more than one WPC Pilot.

Homeless Enrollee Demographics, Health Status, and WPC Service Use

Of the 108,667 total enrollees, 104,691 were successfully identified as Medi-Cal enrollees during PY 2 or PY 3. Of these, 42% of enrollees were identified as homeless (Exhibit 184). The majority of these enrollees were male (64%), 38% were 50-64 years old, and 31% were White. Homeless enrollees differed in these and other characteristics from those not identified as homeless.

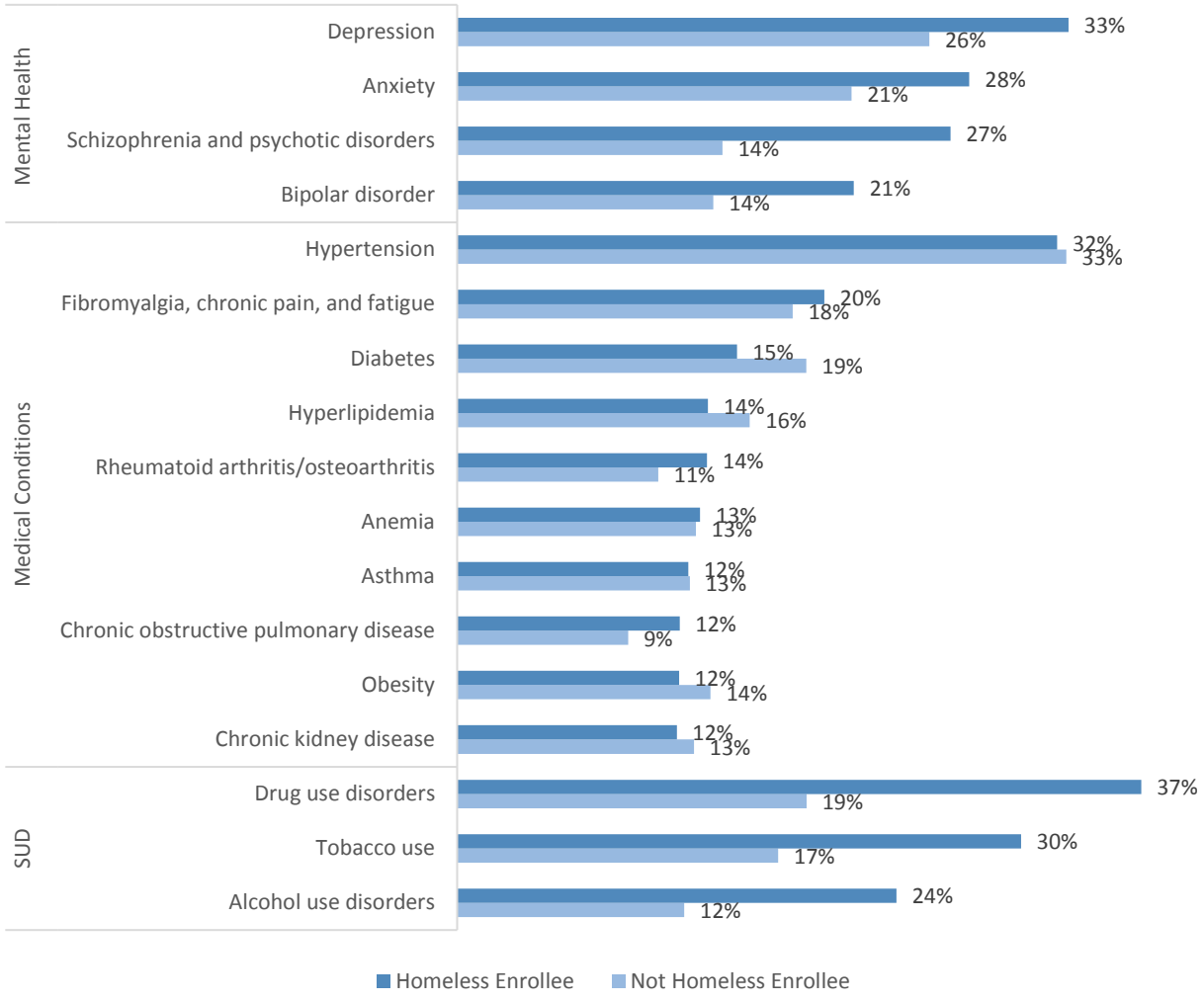
Exhibit 184: WPC Homeless Enrollee Demographics



Source: Medi-Cal enrollment and claims data from 2015-2018 and *WPC Enrollment and Utilization Reports* from PY 2 to PY 3.
Notes: Includes 104,691 individuals identified as enrolled during PY 2 or PY 3 and with sufficient Medi-Cal enrollment and claims data.

Analyses of Medi-Cal claims show that depression (33%), anxiety (28%), and schizophrenia and psychotic disorders (27%) were more prevalent among the homeless enrollees (Exhibit 185). Similarly, drug use disorders (37%), tobacco use (30%), and alcohol use (24%) were more prevalent among the homeless enrollees than others. Among medical conditions, hypertension (32%) was less frequent among the homeless but the rate was similar for this condition with enrollees not identified as homeless.

Exhibit 185: WPC Homeless Enrollee Chronic Conditions

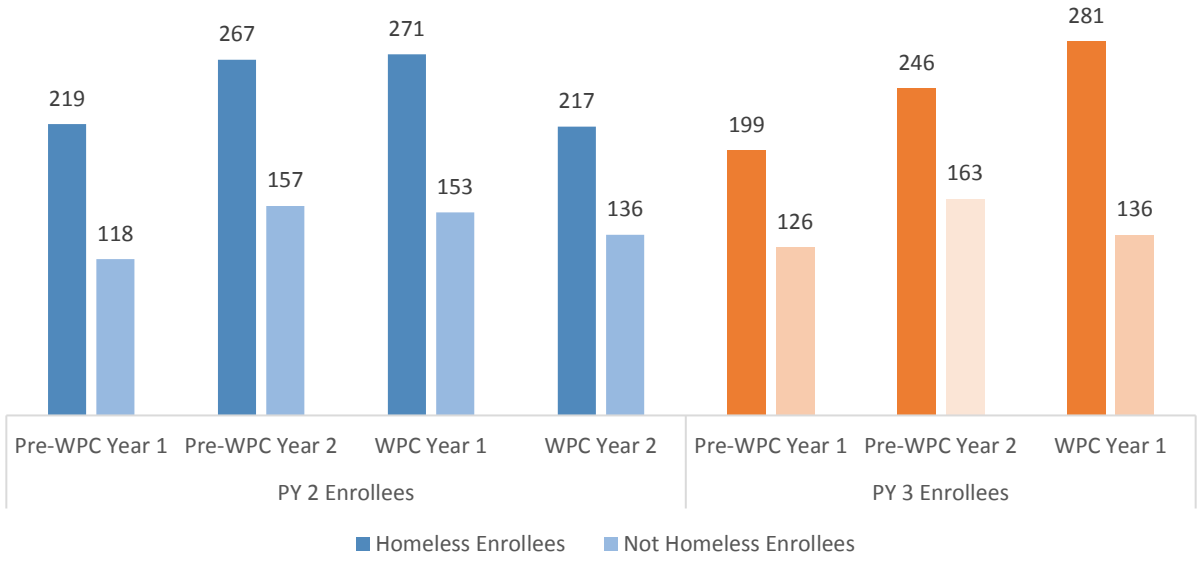


Source: Medi-Cal claims data from January 2015 to December 2016 and *WPC Enrollment and Utilization Reports* from January 2017 to December 2018.
Notes: Chronic and disabling conditions were determined using algorithms developed by the CMS Chronic Conditions Data Warehouse (CCW). Patients with these conditions were identified based on the primary and secondary diagnosis in each encounter and claim. Only conditions with over 10% prevalence among homeless enrollees were included. SUD is Substance Use Disorders.

Unadjusted Trends in Utilization of Acute Care Before and After WPC Enrollment

UCLA created emergency department (ED) and inpatient hospitalization rates using Medi-Cal claims data. Please see Appendix A for further information on how these rates were created. Examining rates of ED visits for enrollees that enrolled in PY 2 showed this rate was increasing prior to WPC enrollment among the homeless. In WPC Year 1, the rate showed a lesser increase from 267 to 271 visits per 1,000 Medi-Cal member months. However, this rate declined in WPC Year 2 or the second year of enrollment in WPC to 217 per 1,000 (Exhibit 186). Homeless enrollees had higher rates of ED visits than not homeless enrollees and the decline from WPC Year 1 to WPC Year 2 for homeless enrollees was greater (a decline of 54 visits vs. a decline of 17 visits per 1,000). The same pattern was observed for homeless enrollees that enrolled in PY 3 but the peak rate of ED visits for this group was 281 visits per 1,000. In comparison, this rate declined for not homeless enrollees, sooner or in WPC Year 1.

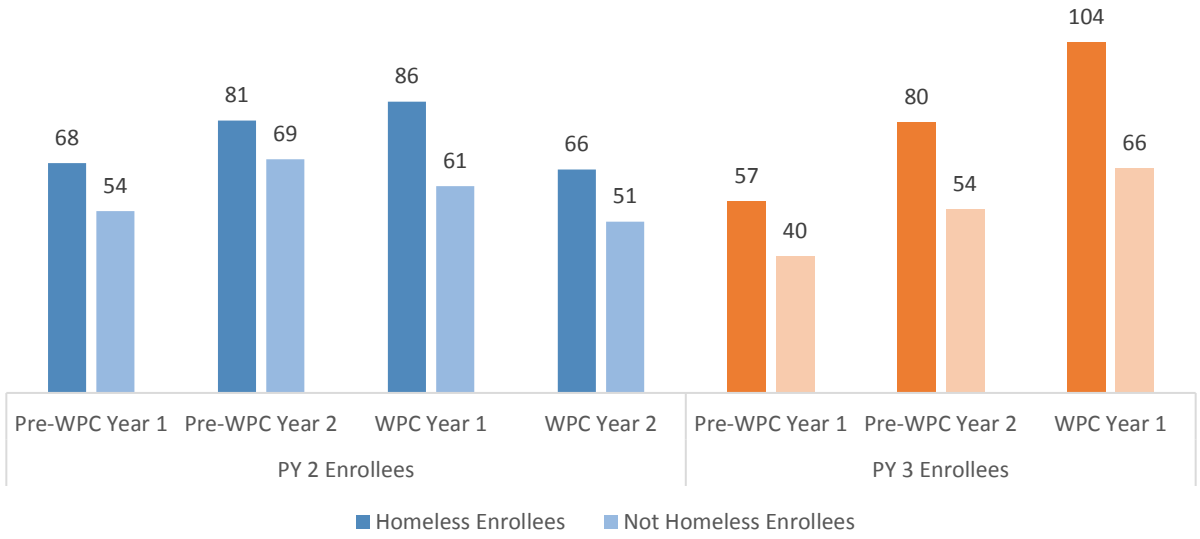
Exhibit 186: Unadjusted Rate of Emergency Department Visits per 1,000 Medi-Cal Member Months by Homeless Enrollees and Not Homeless Enrollees, Before and After WPC Enrollment



Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018 and Medi-Cal Enrollment, Claims and Encounter Data from January 2015 to December 2018.
Notes: Includes 96,868 WPC enrollees with sufficient Medi-Cal enrollment, claims and encounter data in the baseline and enrollment period. Excludes emergency department visits that results in an inpatient admission. Rates are calculated based on first enrollment into WPC.

Examining the rate of hospitalization by homeless status of enrollees showed similar patterns to those observed for ED visits. For example, hospitalization rates declined from 86 in WPC Year 1 to 66 per 1,000 Medi-Cal member months in WPC Year 2 for homeless enrollees that enrolled in PY 2 (Exhibit 187). This decline of 20 hospitalizations per 1,000 was greater than a decline of 10 per 1,000 for not homeless enrollees.

Exhibit 187: Unadjusted Rate of Hospitalization per 1,000 Medi-Cal Member Months by Homeless Enrollees and Not Homeless Enrollees, Before and After WPC Enrollment



Source: *WPC Enrollment and Utilization Reports* from January 2017 to December 2018 and Medi-Cal Enrollment, Claims and Encounter Data from January 2015 to December 2018.
Notes: Includes 96,868 WPC enrollees with sufficient Medi-Cal enrollment, claims and encounter data in the baseline and enrollment period. Rates are calculated based on first enrollment into WPC.

Trends in Pilot-Reported Housing Metrics

UCLA could not replicate housing-related metrics using Medi-Cal data. Therefore, Pilot-reported data were used to calculate the weighted average rates for all three housing services variant metrics (Exhibit 188). These metrics were not available for Pilots that had lacked data, did not enroll homeless, or did not deliver services to those enrolled in the reporting period. See Appendix B for further details on reporting for each metric, including when Pilots reported on each metric. These gaps in Pilot-reported data led to inconsistencies or appearance of poor performance. These gaps are highlighted when appropriate.

Other factors impacted the analyses of these data. For example, Pilot-reported metrics were reported in the aggregate by each Pilot and could not be reported for PY 2 and PY 3 enrollees separately. In addition, they were based on a different population of enrollees in each measurement year and were reported for a calendar year rather than years before and after WPC enrollment.

Exhibit 188: Housing Metrics Selected by WPC Pilots

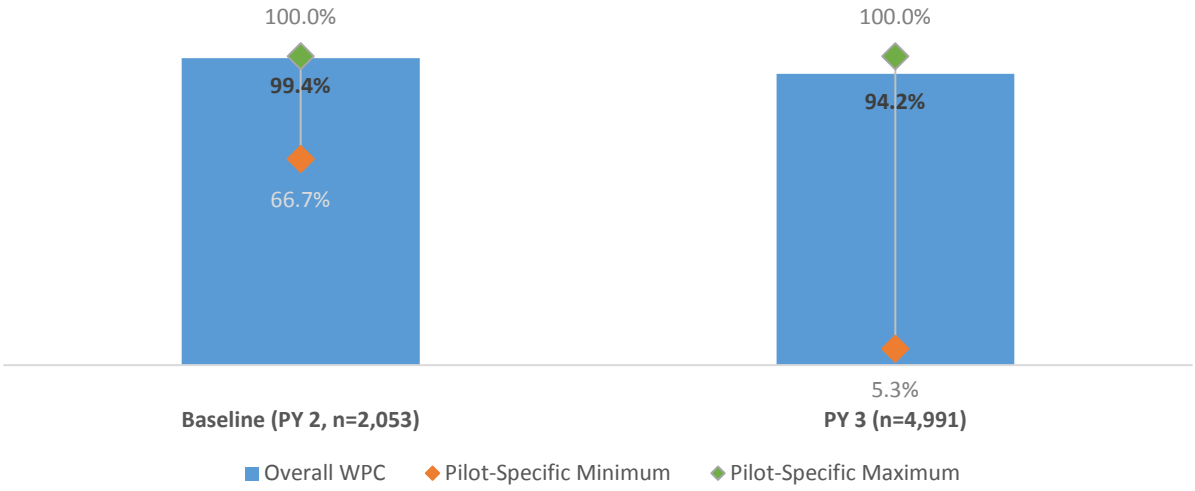
Universal vs. Variant	Metric Name and Number	Description	Baseline Year	Reporting Years	Numbers of Pilots Reporting by Year	Improvement Measured by Increase or Decrease
Variant	3.2.1: Permanent Housing (PH)	PH: Percent of homeless who were permanently housed longer than 6 consecutive months' experience of permanently housed	PY 2	PY 3	4 in PY 2 9 in PY 3	Increase
Variant	3.2.2: Housing Services (HS)	HS: Percent of homeless who received housing services after being referred for housing services	PY 2	PY 3	12 in PY 2 13 in PY 3	Increase
Variant	3.2.3: Supportive Housing (SH)	SH: Percent of homeless who received supportive housing after being referred for supportive housing	PY 2	PY 3	6 in PY 2 6 in PY 3	Increase

Source: PY 1 (baseline), PY 2, and PY 3 Annual WPC Variant and Universal Metric Reports and Whole Person Care Universal and Variant Metrics Technical Specifications (March 22, 2019)

Variant Metric 7: Permanent Housing

Ten WPC Pilots selected to report the percentage of homeless enrollees who were permanently housed and reached seven months of permanent housing (PH) during the measurement year. These Pilots reported that they permanently housed 2,041 and 4,704 enrollees in PY 2 and PY 3, respectively. Despite this growth, the overall PH rate decreased from 99.4% in PY 2 to 94.2% in PY 3 (Exhibit 189). This decline was influenced by six Pilots that did not report in PY 2 because there was insufficient enrollment to calculate the metric for that year. Among those Pilots that reported both years, their rate remained steady from PY 2 to PY 3 (99.6% to 99.5%; data not shown). The PH rates varied more in PY 3 (5.3% to 100%) than in PY 2 (66.7% to 100%).

Exhibit 189: Proportion of Formerly Homeless Enrollees in Permanent Housing for Six Months Who Reached the Seventh-Month, by Program Year

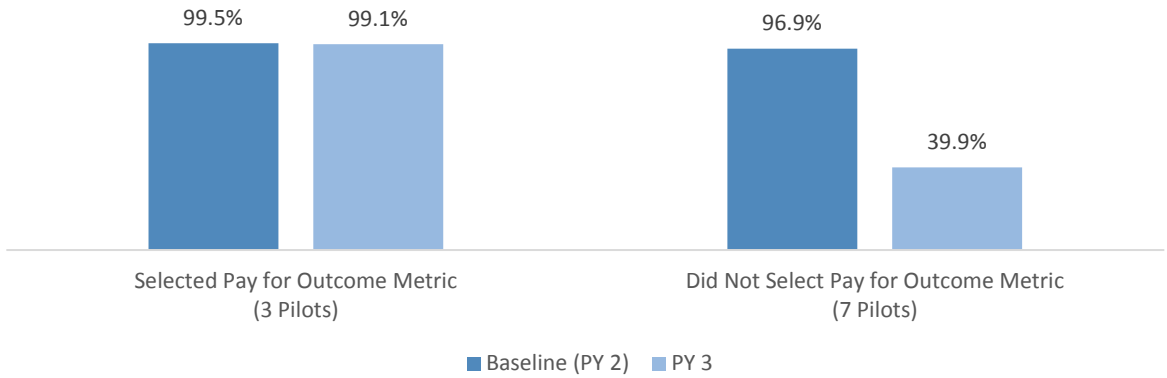


Sources: PY 2 and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. The denominator size is shown as sample size per year. Appendix B, Exhibit 8 provides details on which Pilots reported in each year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot.

An analysis of PH rates stratified by Pilots that targeted homeless or at-risk-of-homelessness enrollees and those that did not was not included due to sparse data among Pilots that did not target this group.

Of the ten Pilots that elected to report on the PH metric, three had P4O incentives for a similar performance measure. These Pilots enrolled over 90% of the homeless enrollees included in this metric and maintained a nearly perfect performance from PY 2 to PY 3. In contrast, this rate declined from 96.9% to 39.9% in the same time period for Pilots without a P4O (Exhibit 190). This decline was influenced by lack of data from one Pilot in PY 2 and a reported rate of 5.3% in PY 3.

Exhibit 190: Percent of Formerly Homeless Enrollees in Permanent Housing for Six Months Who Reached the Seventh-Month, by Whether Pilot Received Pay for Outcome Incentives and Program Year

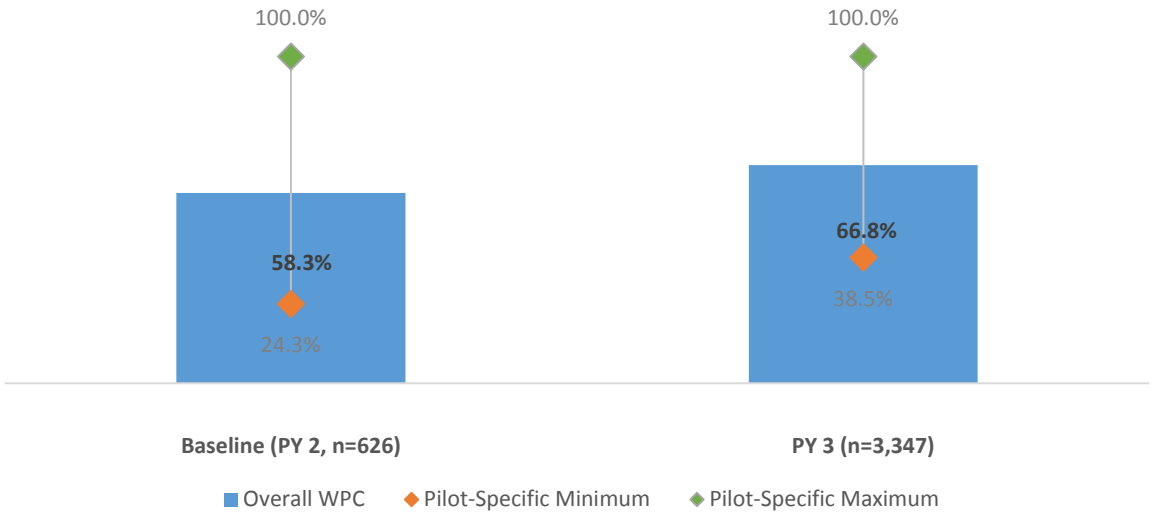


Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Note: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. Appendix B, Exhibit 8 provides details on which Pilots reported in each year.

Variant Metric 8: Housing Services

A subset of 12 WPC Pilots elected to report the proportion of homeless enrollees who received housing services after being referred for housing services (HS). The overall HS rate increased from 58.3% in PY 2 to 66.8% in PY 3 (Exhibit 191). There was large variation in HS rates by Pilot, ranging from a low of 24.3% to a high of 100% in PY 2. Pilots ultimately reported that 443 and 2,670 enrollees received housing services in PY 2 and PY 3, respectively. These counts include data from one pilot that was excluded from the below rate analysis due to differences in their denominator methodology.

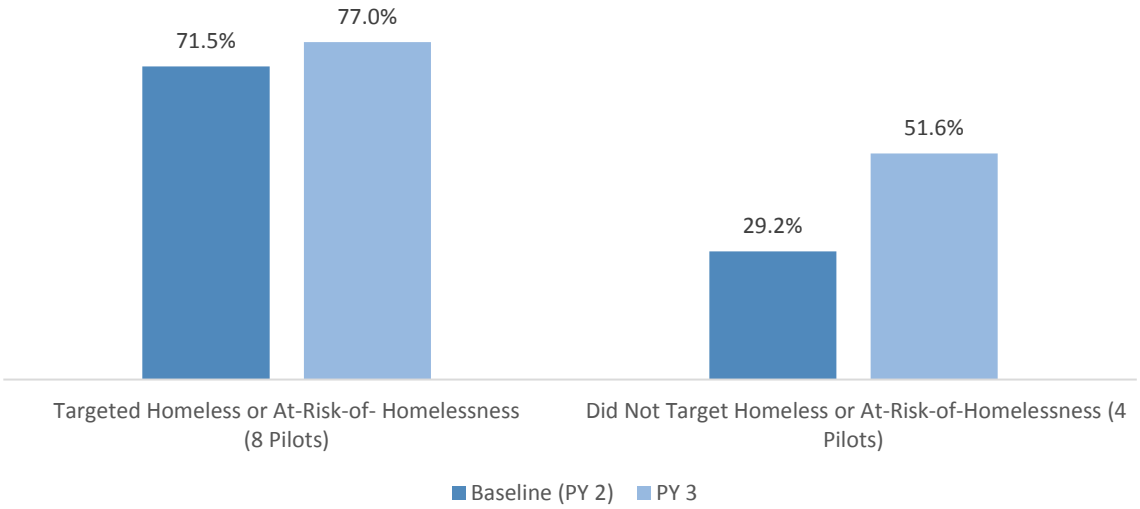
Exhibit 191: Proportion of Homeless Enrollees Who Received Housing Services After Being Referred for Housing Services, by Program Year



Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. The denominator size is shown as sample size per year. These data exclude one large Pilot that included all enrollees in the denominator rather than only those referred for housing services, leading to reported rates of 1.0% in PY 2 and 3.6% in PY 3. The inclusion of this Pilot would have led to a WPC rates of 5.0% in PY 2 and 17.2% in PY 3. Appendix B, Exhibit 9 provides details on which Pilots reported in each year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot.

Examining the HS rate by Pilots that did or did not select homeless or at-risk-of-homelessness as a target population showed that HS rates increased from PY 2 to PY 3 regardless of whether the Pilot selected homeless as a target population (Exhibit 192). However, the rate of HS was lower among Pilots that did not select homeless or at-risk-of-homelessness as a target population.

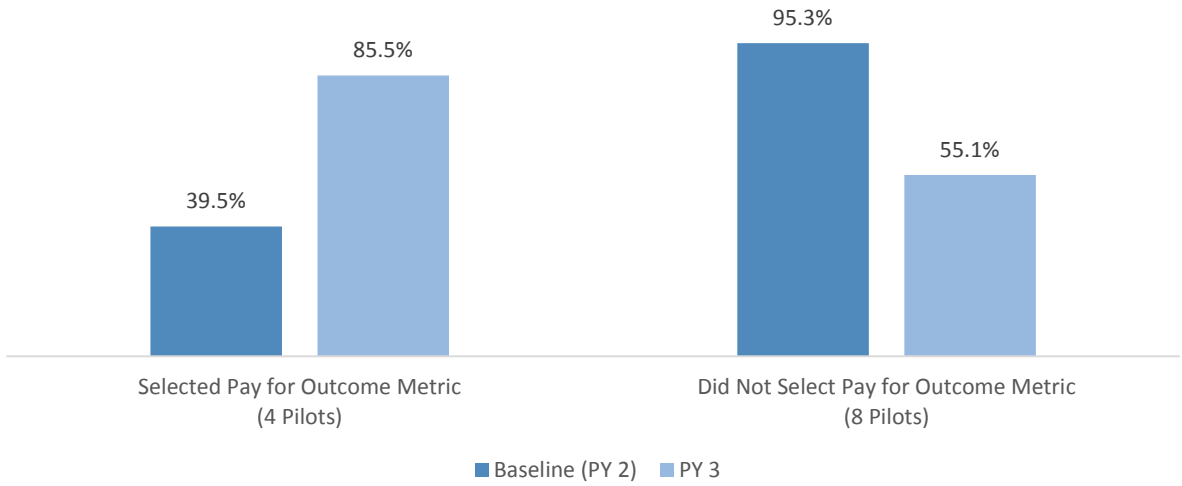
Exhibit 192: Percent of Homeless Enrollees Who Received Housing Services After Being Referred for Housing Services, Among Pilots that Selected Homeless Target Population



Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Data indicated rates among Pilots that selected a given target population and do not reflect rates among enrollees in a target population. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. One Pilot was excluded due to the use of all homeless enrollees as their denominator. Appendix B, Exhibit 9 provides details on which Pilots reported in each year.

Four of the 12 Pilots (listed in Appendix B, Exhibit 9) that selected to report on this metric had a P4O incentive for a similar performance measure. Pilots with P4O had overall lower rates than Pilots without P4O in PY 2 (Exhibit 193). Pilots with P4O reported an increase from 39.5% to 85.5% from PY 2 to PY 3 for this metric. However, those that did not select to receive P4O showed a decline from PY 2 to PY 3. The data for Pilots without a P4O was influenced by one Pilot that had very small enrollment in PY 2 and 100% success in providing housing services and a dramatic increase in enrollment, many of which were less prepared to receive housing services, in PY 3 and therefore less success in this metric.

Exhibit 193: Proportion of Homeless Enrollees Who Received Housing Services After Being Referred for Housing Services, by Whether Pilot Received Pay for Outcome Incentives and Program Year



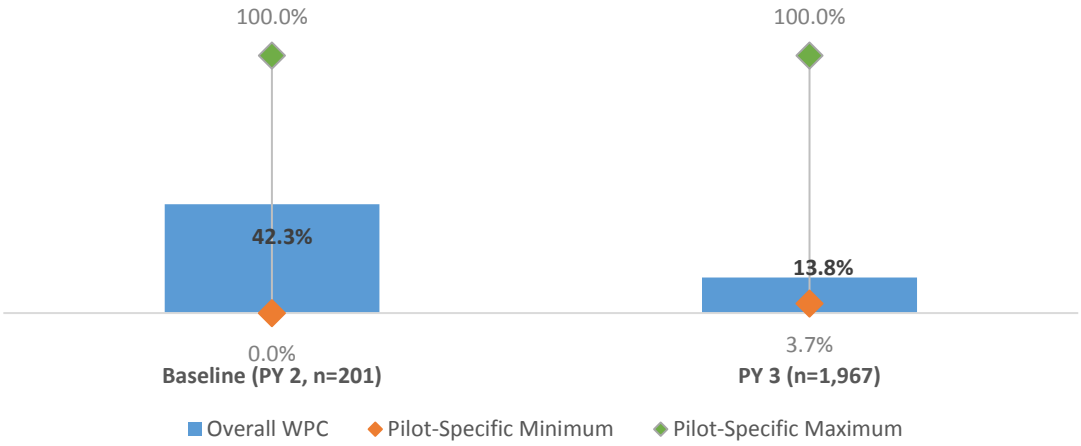
Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. One Pilot was excluded due to the use of all homeless enrollees as their denominator. Appendix B, Exhibit 9 provides details on which Pilots reported in each year.

Variant Metric 9: Supportive Housing

A subset of five WPC Pilots elected to report the percentage of homeless enrollees who received supportive housing after being referred for supportive housing (SH). The overall SH rate decreased from 42.3% in PY 2 to 13.8% in PY 3 (Exhibit 194). There was large variation in SH rates by Pilot, ranging from a low of 0% to a high of 100% in PY 2. Pilots ultimately reported that 399 and 1,104 enrollees received supportive housing in PY 2 and PY 3, respectively. These counts include data from one pilot that was excluded from the below rate analysis due to differences in their denominator methodology.

Further assessment of these rates showed that the one Pilot reporting a rate of 0% had fewer than 10 enrollees in PY 2. Another Pilot accounted for 63% (PY 2) and 86% (PY 3) of the denominator and reported rates of 37.0% in PY2 and 3.7% in PY 3. These data were based on very small enrollment in PY 2, a sudden increase in demand due to large growth in enrollment and an implementation of new system for coordinating housing and housing assistance in PY 3. Calculating the SH rate without this pilot resulted in SH rates of 51.4% (PY 2) and 77.3% (PY 3; data not shown).

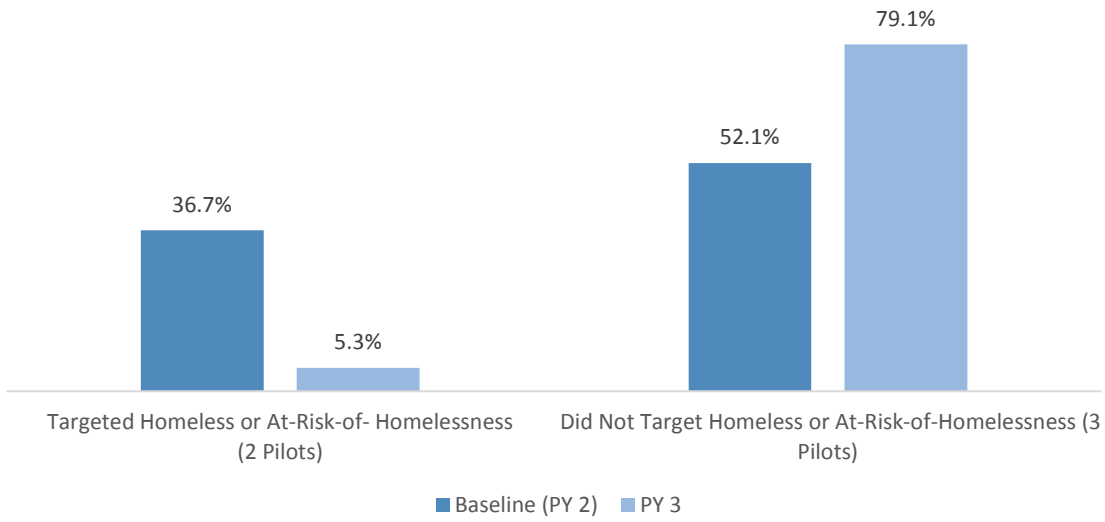
Exhibit 194: Proportion of Homeless Enrollees Who Received Supportive Housing After Being Referred, by Program Year



Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. These data exclude one large Pilot that included all enrollees in the denominator rather than only those referred for supportive housing, leading to reported rates of 3.8% in PY 2 and 6.8% in PY 3. The inclusion of this Pilot would have led to a WPC rates of 4.8% in PY 2 and 7.8% in PY 3. The denominator size is shown as sample size per year. Appendix B, Exhibit 10 provides details on which Pilots reported in each year. Bars represent the range reported by Pilots, with minimum being the lowest rate reported by a Pilot and maximum being the highest rate reported by a Pilot.

Examining the SH rate by Pilots that did or did not select homeless or at-risk-of-homelessness as a target population showed an increase in SH regardless of whether Pilots had selected homeless or at-risk-of-homelessness as a target population (Exhibit 195). Among Pilots that selected homeless or at-risk-of-homelessness target populations, the SH rate decreased from 36.7% to 5.3% from PY 2 to PY 3, with rates lower than Pilots that did not select this target population group. These rates were largely influenced by one Pilot that reported a decline in PY 3 due to significant growth in enrollment and use of a new system for housing and housing assistance, therefore significantly increasing its denominator, and thereby decreasing its rate. No Pilots with reportable data selected this metric as P4O.

Exhibit 195: Percent of Homeless Enrollees Who Received Supportive Housing After Being Referred, among Pilots that Selected Homeless Target Population



Source: PY 2 Annual, and PY 3 Annual WPC Variant and Universal Metric Reports.
Notes: Data indicated rates among Pilots that selected a given target population and do not reflect rates among enrollees in a target population. Only Pilots that reported on this metric were included in the analysis. The number of Pilots reporting varied by year. One Pilot was excluded due to the use of all homeless enrollees as their denominator. Appendix B, Exhibit 10 provides details on which Pilots reported in each year. Missing measurement years was due to lack of data or denominators less than 11.

Challenges and Solutions

In follow-up interviews and narrative reports, common challenges Pilots faced included: coordinating care and linking enrollees to housing services, collecting data to measure housing outcomes, and a lack of affordable housing stock. Some Pilots noted that access to secure and stable housing was key for enrollees to improve their overall health. Pilots have attempted to

work with local partners to secure access to low-income housing, but many have noted that WPC efforts weren't enough to overcome this challenge. Selected examples of housing challenges related to these elements are provided in Exhibit 196.

Exhibit 196: Selected Examples of Challenges to Promote Housing for Homeless Enrollees in WPC

Challenge	WPC Pilot	Selected Examples
Care coordination	Kern	Kern's care coordination team faced challenges in linking patients to affordable housing that matched the limited incomes of their patients.
	Napa	Napa faced unexpected challenges in care coordination when their homeless service system moved to a Housing First service model. Napa expected the goals of the housing-first service model to naturally align with standard service coordination. However, staff required additional supervision, training, and support to better understand the role and need for care coordination for homeless enrollees.
	Shasta	Shasta noted that following the depletion of housing stock due to local area fires, their community placed greater focus on affordable housing options. As a result, considerable focus was taken away from care coordination and seamless service delivery in the Pilot.
Data collection	Napa	Napa faced challenges tracking some data for outcomes improvement because HMIS didn't always capture everything their program wanted to analyze to evaluate program operations and client outcomes. Additionally, Napa mentioned that training service staff new to some requirements to standardize data entry was time consuming.
	San Mateo	San Mateo collected data from multiple sources and not all sources contained information on an enrollee's housing status. San Mateo also faced challenges in having the most updated housing status of enrollees due to the housing status of enrollees frequently changing.
Lack of affordable housing	Alameda	Alameda noted that housing navigators were taking longer to find housing opportunities for enrollees due to a growing lack of affordable housing in the Bay Area. As a result, housing navigators often seized housing opportunities upon immediate availability whether or not it was the best situation for enrollees, leading to less stable housing situations.
	Mendocino	Mendocino enrolled more homeless WPC beneficiaries than previously projected, but was challenged with a lack of affordable housing for enrollees. Mendocino noted that housing was important to support physical and mental health and to work towards goals aimed at sobriety or overall health improvement.
	Sacramento	Sacramento faced challenges in a lack of affordable private market housing, publicly subsidized housing, and housing support services for their target population. Sacramento noted that there was significant need for housing options that provided a higher-level of care for WPC target populations, board and care, assisted living, and room and board.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019 and Whole Person Care Program Mid-Year and Annual Narrative Reports (n=25), January 2017-March 2019.

The housing challenges were not easily resolved. Yet, effectiveness of housing and providing supportive services to homeless enrollees was viewed as moderately successful by Pilots. In interim surveys, Pilots and partners were asked about the effectiveness of the WPC program in

achieving organization-focused goals on a scale of zero (not effective) to ten (extremely effective). Pilots indicated greater effectiveness in increasing client/patient access to housing and supportive services (7.2 of 10) compared to partner organizations (6.8, data not shown).

Chapter 14: Lower Costs

WPC was expected to decrease costs through reductions in avoidable utilization. In the final report, UCLA will address the following evaluation question: "to what extent did WPC pilots reduce costs of care for enrolled beneficiaries compared to the control group and were total Medi-Cal expenditures reduced during the pilot?" As outlined in the evaluation design, UCLA will assess changes in costs for targeted beneficiaries as well as a subsequent reduction in Medi-Cal expenditures overall. These analyses was not conducted since the program was being implemented.

Chapter 15: Sustainability

WPC was expected to enhance sustainability of infrastructure improvements and program interventions. In the final report, UCLA will address the following evaluation question: "to what extent will lasting collaboration between pilot participants and care coordination protocols continue after the Pilot? How will counties ensure that improvements achieved by the Pilots are sustained after Pilot funding is exhausted?" As outlined in the evaluation design, UCLA will assess sustainability of WPC by analyzing the degree to which Pilots embedded care coordination activities and integration in their operations and whether they reported plans for continuing these activities after WPC had ended.

At the time of this report, some WPC Pilots had begun sustainability conversations that often involved identifying critical elements to be maintained after WPC. In follow-up interviews, Pilots considered three aspects of WPC prioritized for sustainability: (1) care coordination infrastructure and processes, (2) partnerships, and (3) a common electronic data platform.

Within care coordination, Pilots considered the multi-disciplinary team approach was a key component to sustain. Pilots also anticipated retaining some partnerships, particularly in response to Senate Bill (SB) 1152 (Hernandez, Chapter 981, Statutes of 2018) that requires hospitals to have a homeless patient discharge planning policy and process, track discharged homeless patients, and develop a written plan to ensure appropriate post hospital care. SB 1152 was seen as a motivator for maintaining partnerships with hospitals around homeless enrollees. Pilots further expected sustaining the WPC data infrastructure because the system had proven too valuable to become obsolete. Exhibit 197 highlights selected examples of sustainability considerations and/or plans by Pilots.

Exhibit 197: Selected Examples of Key WPC Elements Considered for Sustainability

WPC Element to Be Sustained	WPC Pilot	Selected Examples
Care coordination	Contra Costa	Contra Costa emphasized the efforts taken to establish a strong workforce to deliver care coordination activities, including implementing training programs. Contra Costa believe this training, with an emphasis on social determinants of health, would work to ensure the existing care coordination culture, practices, and workflows will be sustainable once funding ends.
	Mariposa (Small County Collaborative)	Mariposa stated they have found great value of their multi-disciplinary team model and have implemented these care coordination activities into their full service partnerships to ensure longevity of the WPC model for care coordination.
Partnerships	Placer	Placer identified the strong partnerships established with managed care plans and local hospitals as critical to continuing their work. The LE and partners are working together to identify both external and internal funding opportunities.

WPC Element to Be Sustained	WPC Pilot	Selected Examples
	San Bernardino	San Bernardino and partners have started conversations on how the care coordination model can be replicated in other existing departments after WPC funding ends. The Pilot views partnerships as foundational to effectively coordinating services.
Data sharing infrastructure	Marin	Marin is in the process of establishing a sustainability plan; a key element of the plan is to formalize data sharing provisions to ensure participant's adherence after WPC.
	Sonoma	Through Sonoma's close working relationship with IBM Watson (host of case management platform), the Pilot aims to prioritize sustaining data infrastructure beyond the life of the Pilot. Other programs in the county are using the platform for their clients, increasing the likelihood the platform will remain active after the life of the Pilot.

Source: Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

At the time of follow-up interviews, 22 Pilots (88%) participated in informal discussions on sustainability within the Lead Entity (data not shown). Six Pilots (24%) indicated formal meetings with leadership and six Pilots (24%) indicated having an established sustainability plan. Only four Pilots (16%) indicated formal meetings regarding sustainability with partners (data not shown).

> *"A five year time horizon is really short. Like, it doesn't seem like it is, but it is incredibly short. We spent the first year planning it, the second year kind of explaining to everybody what we were doing getting their systems and everything worked, and so it's really only this year where we're hitting our stride, providing the services, and we're already talking about winding down."*
>
> *-Ventura*

In discussing sustainability, WPC Pilots frequently mentioned uncertainty around future funding to support WPC infrastructure and activities. They also noted that assessing the value of WPC impact required a longer than the five-year project timeline. Some Pilots expressed apprehension about their ability to solely demonstrate WPC impact through required reporting (e.g., metrics) as social determinants of health and other more qualitative components were viewed as critical program elements that were difficult to systematically capture.

Chapter 16: Conclusions

This interim report presented the findings of the first three years of the comprehensive state-wide evaluation of WPC in California. The report provided extensive evidence of how the infrastructure for WPC implementation was developed by WPC Pilots, what processes were followed to implement the program, what services were delivered, and whether WPC led to better care and better health.

Motivation for WPC Participation

The evaluation included an assessment of why Pilots chose to participate in WPC in order to promote a better understanding of the overall program approach. Available data showed that Pilots were highly motivated to participate in WPC primarily because WPC fit their strategic priorities, was synergistic with other concurrent initiatives, and was considered an important goal of the organization. This high level of consistency between WPC and Lead Entities' (LEs) strategic priorities, as well as partners' goals, was likely to have played an important part in successful implementation of the program, enrollee outcomes, and its future sustainability.

Structure of WPC Pilots

Two evaluation questions were designed to illustrate the structural differences of various Pilots and the extent to which they developed partnerships within county organizations and community providers. The findings showed that Pilots chose Lead Entities that had the leadership and administrative capacity to implement WPC. While the majority of LEs were health services or public health departments and agencies, a small proportion included behavioral health departments and health systems. Pilots varied in size, type, and whether partners were external organizations, frequently in accordance with selection of target populations. These choices had implications for the role of various partners. For example, more community partners provided services and had limited involvement in planning and decision-making activities than partners that were county organizations. Partnership efforts appeared to have largely succeeded based on relatively high ratings of buy-in from and increases in interactions with partners. Similarly, success was evident by relatively high ratings of partners' perceptions of effectiveness of WPC in achieving goals; improvements in aspects of care attributable to WPC; and improved collaboration and interaction with other partners. These successes were achieved through continuous efforts to develop new and maintain existing partnerships across the spectrum of internal and external partners.

Health Information Technology and Data Sharing Infrastructure

One evaluation question was designed to illustrate the extent to which Pilots improved data collection and information sharing capacity to promote successful management of enrollees and improve outcomes. Pilots began WPC with different degrees of data sharing infrastructure but collectively made progress in increasing their capacity, though gaps in ability to share data with internal and external partners remained. Elements of success included systematically establishing agreements with partners and a single universal enrollment consent form, providing needed tools for management of patients, and establishing HIEs. Pilots who already had a common data sharing platform often faced fewer initial barriers to implementation. One specific accomplishment was establishing a case management tool under WPC, which was rare prior to WPC. Despite gaps in data infrastructure, Pilots found ways to share the most important data needed for outreach and enrollment, monitoring partner performance, and quality improvement activities. Real-time data sharing was consistently available for about half of Pilots, highlighting areas of improvement for the remaining years of WPC. The type of challenges that Pilots faced in data sharing were often rooted in organizational silos that restricted ability to collaborate and share data. Overcoming these challenges required extensive efforts but Pilots frequently devised technical and interpersonal solutions to make progress in data sharing. Pilots often viewed data sharing as a priority and important for sustaining WPC.

Identification, Enrollment, and Engagement of Eligible Medi-Cal Beneficiaries

WPC Pilots were required to identify eligible Medi-Cal beneficiaries following DHCS eligibility requirements for WPC but could further refine their inclusion criteria to fit their programs' focus. Pilot approaches to identification of eligible enrollees matched their target populations and were designed to find prospective enrollees where they lived and gathered, including streets and shelters. This was an important strategy, particularly for Pilots that targeted the transient homeless populations who could not be found with traditional modes of communication and required intensive efforts to develop rapport and trust in order to enroll them in WPC or provide limited, but necessary services. Following enrollment, similar multimodal approaches to communication were required to engage and retain enrollees and maintain trust. These efforts led to significant growth in WPC enrollment starting in PY 2 and PY 3 with limited churn, or successful retention of enrollees. The patterns of enrollment showed long-term enrollment for many, but length of enrollment was confounded by gradual roll out of WPC by different Pilots and Pilot's decisions on whether to graduate enrollees or allow continued enrollment because of the severity of conditions or needs. Pilot's decisions to

attribute enrollees to target populations was not transparent in the available data. Yet, attribution of enrollees to high utilization and homeless target populations highlighted the consistency in Pilots' approach to enrollment with the overarching goals of WPC.

WPC Services Offered and Delivered

One evaluation question was designed to illustrate the services WPC enrollees were offered and received. Consistent with the goals of WPC, all Pilots offered care coordination and housing services. However, evidence indicated that some enrollees did not receive these services because further assessment indicated their needs were different. WPC allowed Pilots to deliver basic services, such as linkages to service providers prior to enrollment. This flexibility in service delivery expanded the reach of the program even when eligible individuals did not enroll in WPC. Assessment of services delivered to enrollees indicated they were frequently aligned with the needs of the target populations, for example, high rates of sobering center use by SMI/SUD enrollees. Variations in attribution of enrollees to a given target population and bundling of services was a barrier to an accurate assessment of which patients received specific WPC services. Nevertheless, assessment of payments by target population was a reasonable proxy for the intensity of service use and showed higher intensity of services to the most challenging enrollees, such as the SMI/SUD group.

WPC Care Coordination

Another evaluation question was intended to highlight the extent to which Pilots provided timely and comprehensive care coordination. Available evidence indicated that Pilots had different approaches to infrastructure development and delivery of care coordination services with varying results. By the end of PY 3, Pilots had successfully formed care coordination teams, shared critical data across sectors despite multiple challenges, standardized protocols to ensure consistency in care coordination activities to some degree, and at times incorporated financial incentives to promote high level of performance from external partners. Evidence also indicated that Pilots anticipated making further progress in addressing tenacious problems and potential ways these problems could be addressed. Areas in need of improvement included (1) further effort in developing the infrastructure for data sharing such as agreements and protocols and systematic use of universal consent forms; (2) promoting person-centered practices to engage vulnerable patients such as conducting field-based outreach and service delivery, using peers with lived experience in care coordination teams, and training staff to improve quality and outcomes of care; and (3) leveraging resources and partnerships to address structural housing problems such as innovative partnerships, promoting partner buy-in, and alignment of financial incentives within contracts with WPC goals.

WPC Performance Improvement and Program Monitoring

Pilots were required to engage in regular performance improvement activities and submit bi-annual Plan-Do-Study-Act (PDSA) reports documenting Pilot-led efforts to improve metric performance. Evidence indicated a significant number of PDSAs were conducted, which were aligned with areas of WPC implementation, such as care coordination, and outcomes, such as hospitalizations. Pilots also received several forms of support from a DHCS analyst and external organizations that organized regular meetings and workgroups and provided technical assistance. Diversity in Pilots' needs such as their focus on different target populations, differences in geographic/local contexts, and their progress in data sharing infrastructure made it challenging for Pilots to effectively learn from one another and establish program-wide "best practices". Other forms of performance improvement activities of Pilots included conducting informal or formal assessments to measure impact, identifying solutions to challenges, justifying level of effort, reallocating funds, and determining which elements to sustain after 2020.

Enrollee Demographics, Health Status, and Prior Health Care Utilization

One evaluation question was designed to illustrate the characteristics of WPC enrollees. Evidence showed that Pilots primarily enrolled Medi-Cal beneficiaries who were frequently men, 50-64 years old, White, English speaking, and enrolled in managed care. These beneficiaries had high rates of hypertension, substance use disorders, and mental health conditions. WPC enrollees also had high rates of service use, particularly SUD services and ED visits and an increase in these rates over time prior to WPC enrollment. Overall, these findings showed that Pilots captured very high need and high cost Medi-Cal patients which was consistent with overarching goals of WPC.

Better Care

Another evaluation question was designed to demonstrate the extent to which Pilots increased appropriate access to care and improved beneficiary care outcomes. Data showed successes in follow-up after hospitalization for mental illness at 7 and 30 days and the rates of initiation and engagement of alcohol and other drug dependence treatment increased for those enrolled during WPC compared to before enrollment regardless of year of enrollment or whether Pilots had incentives through pay-for-outcome. Results also showed that progress for WPC enrollees was greater than the control group. Examination of Pilot-reported data showed improvements in care delivery under WPC, including increased rates of timely provision of comprehensive care plans and suicide risk assessments from the baseline period. Overall, substantial evidence indicated that Pilots successfully provided better care to WPC enrollees.

Better Health

A subsequent evaluation question was designed to demonstrate the extent to which Pilots improved health outcomes. Medi-Cal data showed improvements in rates of ED visits, hospitalizations, and all-cause readmissions in the second year after enrollment for PY 2 enrollees. Among PY 3 enrollees, improvements in ED visits in the first year after WPC enrollment was also observed. Comparing change overtime between WPC and a control group did not show greater improvements in metrics among WPC enrollees in the interim. However, there was evidence that ED visits and all-cause readmission declined more for WPC enrollees compared to the control group from the first to the second year of enrollment. In addition, WPC succeeded in preventing ED visit or hospitalization in comparison to the control group. The evidence provided by Pilots also showed a complex picture of progress under WPC.. Clear improvements in beneficiary overall and emotional health, controlled blood pressure, and A1C were shown, but improvements in indicators of depression remission were not observed. Overall, data provided some evidence of improved health, which could not be fully attributed to WPC in the interim evaluation period. But these trends may change with longer implementation of WPC.

Homeless WPC Enrollee Services and Outcomes

Another evaluation question was intended to demonstrate the extent to which WPC increased access to housing and supportive services and improved housing stability. This was an important service as nearly half of WPC enrollees were homeless across all target populations and regardless of Pilots' focus. The examination of homeless characteristics showed that these enrollees had high prevalence of SMI and SUDs and high frequency of ED visits and hospitalizations. The profile and living conditions of homeless enrollees necessitated strategic and innovative approaches in outreach and delivering services to homeless populations where they congregated, developing and using tools to track them, adding dedicated housing care coordinators, and using specific engagement methods to promote trust and rapport. The assessment of outcomes after two years of WPC enrollment showed early successes in delivery of housing services and receipt of supportive housing but also challenges in retaining permanent housing. Analyses of Medi-Cal Data also indicated promising reductions in ED visits and hospitalization. A major issue in addressing housing challenges for homeless enrollees was lack of funding to directly provide housing and lack of adequate housing supply. Some Pilots leveraged other funding sources and worked with external partners to mitigate these challenges. Overall, substantial evidence was provided to show delivery of housing services and potential success in reducing ED utilization.

Lower Costs and Sustainability

Two final evaluation questions were designed to assess the role of WPC in reducing costs for WPC enrollees and Medi-Cal overall and the extent to which care coordination and partnerships were sustained after the end of WPC. Neither question was addressed in this interim report because WPC was still in progress and neither cost reduction nor sustainability could be meaningfully determined. However, limited information was provided by Pilots as they shared early thoughts on sustainability of WPC given the level of effort to date. Data implied that sustainability of data sharing infrastructure or meaningful care coordination processes were a priority and were hoping to demonstrate value in order to secure other funding sources beyond 2020.

Next Steps

This interim report provides a comprehensive overview of WPC by the end of the third year of implementation. Additional data will be collected to assess the progress made by Pilots and the subsequent impact on care, health, and costs as well as likelihood of its sustainability for key program elements. The final WPC evaluation will include an assessment of each target population by Pilot and compare the differences in the "package of interventions" of the various Pilots to potentially identify services that improve outcomes. Additionally, the final report will attempt to identify key factors that aided or hindered the success of specific strategies in implementation and in achieving intended outcomes. Sustainability efforts and progress in specific aspects likely to have changed, such as data sharing, will be reexamined in a follow-up survey of Pilots. Additional Pilot-reported data will be used to assess progress particularly in improvements in metrics that could not be independently evaluated. The final report will also include an assessment of better care and better health metrics using Medi-Cal data from the last two years of WPC as well as trends in WPC enrollees and overall Medi-Cal expenditures before and after WPC.

Appendix A: Data and Methods for Medi-Cal Metrics, Control Group Construction, and Difference-in-Difference (DD) Analysis

UCLA obtained administrative Medi-Cal monthly enrollment and claims data for the calendar years 2015 to 2018 for all individuals reported as individuals that interacted with WPC. These years included two years prior to WPC enrollment, including 2015 and 2016 (PY 1), and the first two years of WPC enrollment (PY 2 and PY 3).

The WPC enrollees and individuals who ever received services from the program (N=122,888) were identified from *WPC Enrollment and Utilization Reports* submitted by Pilots to DHCS quarterly between PY 2 and PY 3. Individuals who were enrolled in WPC during PY 2 and PY 3 were identified and selected for the DD analyses. This led to exclusion of 14,202 individuals who were never identified as enrolled in Pilot reports (Exhibit 113). Comparing Pilot enrollment with administrative Medi-Cal enrollment led to exclusion of another 2,510 who were not enrolled in Medi-Cal during the baseline period (2015-2016). Another 8,335 enrollees were excluded from the DD analyses because they lacked any Medi-Cal claims data in baseline period. Furthermore, 973 individuals were excluded because due to insufficient reported demographic information. The final WPC enrollee sample for the DD analyses included 96,868 individuals who were enrolled in Medi-Cal and had received health services paid for Medi-Cal in 2015-2016.

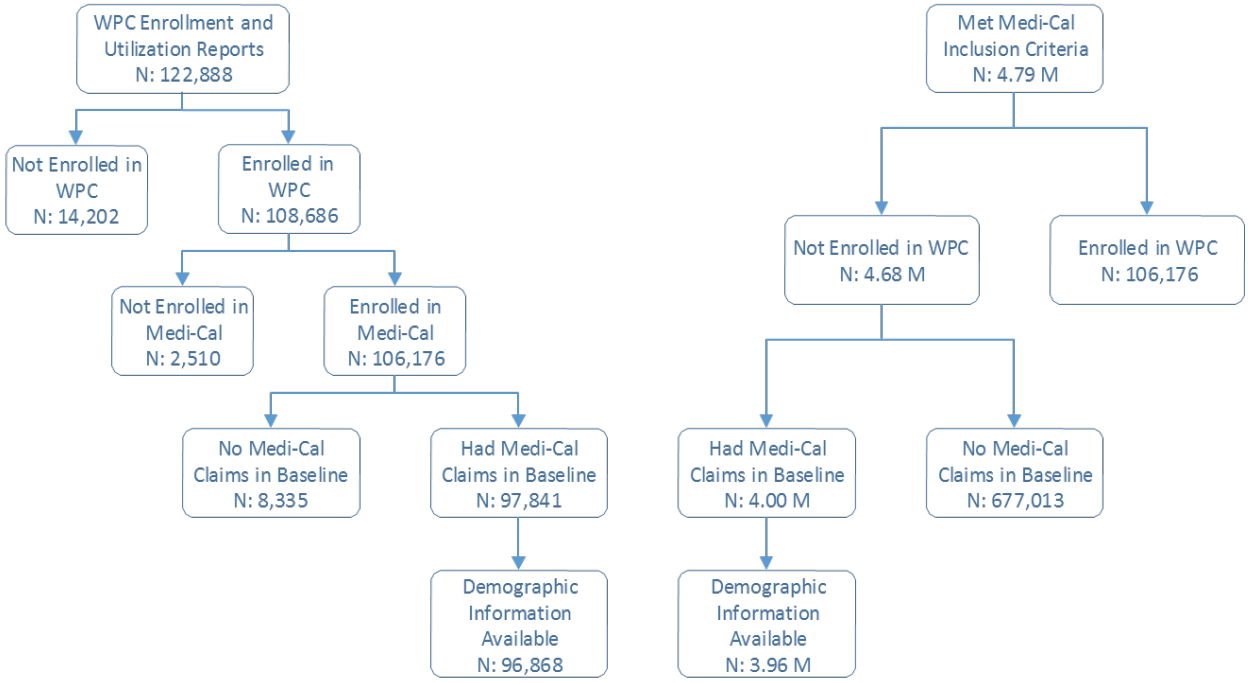
To construct the control group, UCLA requested a preliminary master list of all Medi-Cal enrollees in 2015-2016 who met any of the following criteria:

- At least two emergency department (ED) visits
- At least one inpatient hospitalization
- At least one ED visit with a mental health or substance use disorder diagnosis
- An incarceration aid code (F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, H3, J4, J5, J6, J7, J8, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9)
- Homeless keywords (homeless, no residence/no permanent address, transient, hotel/ motel/manor/lodge, services care/hospital/clinic/health care, pathway/bridge/freeway, jail, unknown/don't know, undomiciled/general delivery/shelter/bus/train station/ airport) in the beneficiary street address

This led to identification of over 4.6 million Medi-Cal enrollees that were not enrolled in WPC. Among this group, over 700,000 individuals without any Medi-Cal claims in the baseline period and sufficient demographic information were excluded from further analyses. These exclusions

led to a reduced master list of 3.96 million Medi-Cal enrollees who were then used to identify the control group for the DD analyses.

Exhibit 1: WPC Enrollee and Medi-Cal Master List Samples



Source: *WPC Enrollment and Utilization Reports,* PY 2 – PY 3, and Medi-Cal Enrollment, Claims and Encounter Data, 2015-2018

Control Group Sample Selection

UCLA used 93 indicators including demographic, health status, and service utilization of the WPC enrollee sample to construct the control group (Exhibit 2). Demographic variables were constructed from Medi-Cal enrollment data and included age at the start of WPC enrollment, gender, county in which enrollment occurred, race/ethnicity, homeless status, and length of Medi-Cal enrollment. Homeless status was obtained from address details, such as whether an address indicated any homeless term or was found not to be a real address. Length of Medi-Cal enrollment was identified by summarizing the number of months enrolled in Medi-Cal during the baseline period. Other indicators such as the number of months enrolled in a managed care and the number of months with full scope coverage in Medi-Cal were also included.

Health status indictors included measures of chronic health conditions (e.g., asthma, diabetes, depression, alcohol use disorder). The indicators were constructed following the Chronic Conditions Data Warehouse (CCW) definitions and instructions managed by the Centers for Medicare and Medicaid Services (CMS). CCW examines the number of times a diagnosis in a given category was reported for an enrollee who had a condition. Additional indicators of any

mental health condition, serious mental illness, and substance use disorder followed further specifications by the Healthcare Effectiveness Data and Information Set (HEDIS).

Utilization variables included the number of emergency department (ED) visits and inpatient (IP) admissions, along with the number of evaluation and management (E&M) visits and mental health services received. UCLA calculated the total sum of ED and IP visits in the pre-enrollment period, as well as the median, minimum number, maximum number, and variance of visits in a given month. UCLA created a measure of severity based on the Chronic Illness and Pharmacy Payment System (CDPS), which is based on number and type of reported International Classification of Diseases (ICD) codes for an individual, using baseline data.

Exhibit 2: Medi-Cal Enrollment and Claims Indicators Used for Control Group Sample Selection

Indicator	Description
Demographics (8 indicators)	
Age	Age at the start of WPC enrollment
County	Reported County of Medi-Cal or WPC Enrollment
Ethnicity	Reported Ethnicity of Medi-Cal or WPC Enrollment
Gender	Reported Gender of Medi-Cal or WPC Enrollment (Male Reference Group)
Enrolled Months in Medi-Cal	Number of months enrolled in Medi-Cal
Managed Care Months in Medi-Cal	Number of months reported as Managed Care
Full Scope Months in Medi-Cal	Number of months in the reported as having full-scope Medi-Cal coverage
Homeless Status	Whether or not homeless keywords were reported in Medi-Cal enrollment
Behavioral Health Condition Status (3 indicators)	
Mental Health Disorder Flag	Whether or not the person received a diagnosis in the *mental health disorder* value set of HEDIS
Serious Mental Illness (SMI) Flag	Whether or not the person received a diagnosis in the *schizophrenia, bipolar disorder,* or *major depressive disorder, recurrent episode* value sets of Chronic Conditions Data Warehouse
Substance Use Disorder (SUD) Flag	Whether or not the person received a diagnosis in the *alcohol disorders, opioid disorders, or other drug disorders* value set of HEDIS
Chronic and Disabling Conditions (66 indicators)	
Chronic Conditions	Whether or not a person met the criteria of Chronic Conditions Data Warehouse 27 *Chronic Conditions*
Chronic Health, Mental Health, and Potentially Disabling Conditions	Whether or not a person met the criteria of Chronic Conditions Data Warehouse 39 *Other Chronic Health, Mental Health, and Potentially Disabling Conditions*
Utilization (16 indicators)	
Claims Records in 2015	Number of days in 2015 on record in claims
Claims Records in 2016	Number of days in 2016 on record in claims
Emergency Department Visits	Total and monthly median, min, max, and variance of emergency department visits

Inpatient Admissions	Total and monthly median, min, max, and variance of inpatient admissions
Short-Doyle	Total number of Short-Doyle visit services
Evaluation & Management Services	Total number of evaluation and management visits
Mental Health Services	Total number of mental health service visits
Average CDPS Risk Score	Chronic Illness and Disability Payment System Score (UCSD)

Using the above variables, the control group was first identified by developing a propensity score that indicated the similarity between an enrollee and an individual in the reduced master list sample. Prior to developing the model, UCLA randomly selected 90% of the reduced master list sample of potential controls (over 1.4 million) to fit a propensity score model, and UCLA used the remaining 10% as a test dataset to evaluate model performance. The sample was further reduced to observations from WPC Pilot counties (over 1.1 million), excluding individuals from other counties because they could not have enrolled in WPC. After pre-processing the data, a propensity score model was created using stochastic gradient boosted trees (xgboost in R) and 5-fold cross validation. This machine learning model captured complex interaction effects between covariates and by model tuning and cross-validation, so that problems of overfitting the data were avoided. On the test dataset, the model performed well with an AUC score of 0.944 and sensitivity/specificity of 0.8011 and 0.8000, respectively.

Due to variation in WPC Pilots and contextual county differences, the propensity score was then calculated at the county level. Since the propensity score model was fit using the county variable as a fixed effect to obtain county-specific counterfactual predictions for each individual, UCLA was able to accommodate for imbalances in sample size from different WPC pilots. This meant creating a county-specific sample of potential controls, which included all individuals with a propensity score of greater than or equal to the 95th percentile of the propensity score of WPC enrollees (i.e., highly similar to current enrollees) and randomly sampling individuals below said threshold.

To assign individuals to matched groups, an exact match in age and gender was performed. Then, the closest possible match based on mental health disorder diagnosis, serious mental illness (SMI) diagnosis, substance use disorder (SUD) diagnosis, months of Medi-Cal enrollment, and months of managed care enrollment was required. UCLA aimed to create a matched sample with a 1:2 ratio (1 WPC enrollee to 2 control individuals) by county, allowing for sampling with replacement.

While each WPC enrollee was matched with two individuals from the control group, because of UCLA's methodology of sampling with replacement and limitations in availability of similar

matches per county, the analyses resulted in a final ratio of 1:1.82 (96,868 distinct WPC enrollees matched with 176,301 distinct individuals from the control group). When an individual in the control group was matched to multiple enrollees in the WPC treatment group, all of the duplicates were assigned a new individual ID to distinguish these matches as if each copy of the duplicate was a distinct individual matching to the treatment individual. This resulted in a balanced sample for further DD analysis.

Characteristics of WPC Enrollees and Control Group

Exhibit 3 shows the mean values of indicators for WPC enrollees, the final control group, and the pre-matched control group. The data indicate that the mean values for the majority of indicators are significantly closer after selection of the final control group than prior to this selection in the larger sample used to select the control group.

Exhibit 3: Differences in Selected Characteristics of WPC Enrollee and Control Group

Covariate	Pre-Matched Control Group Mean (N=3.96 million)	Matched Control Group Mean (N=180,741)	WPC Enrollee Mean (N=96,450)	Std. Diff. Unmatched	Std. Diff. Matched
Demographics					
Age	36.18	43.45	45.95	0.743	0.167
Enrolled Months in Medi-Cal	21.35	20.85	20.81	0.052	-0.007
Managed Care Months in Medi-Cal	17.80	17.37	17.05	0.113	-0.037
Chronic Conditions					
Mental Health Disorder	0.41	0.51	0.50	0.631	-0.007
Serious Mental Illness (SMI)	0.19	0.26	0.26	0.457	0.008
Substance Use Disorder (SUD)	0.18	0.25	0.25	0.457	0.014
Alcohol Use Disorder	0.05	0.07	0.08	0.231	0.051
Anxiety	0.13	0.13	0.14	0.234	0.028
Asthma	0.07	0.04	0.06	0.074	0.070
Chronic Obstructive Pulmonary Disease	0.05	0.03	0.05	0.117	0.065
Depression	0.17	0.19	0.20	0.332	0.033
Diabetes	0.10	0.11	0.13	0.130	0.045
Hyperlipidemia	0.06	0.06	0.07	0.043	0.040
Hypertension	0.17	0.19	0.21	0.227	0.056
Obesity	0.06	0.05	0.05	0.041	0.032
Stroke	0.01	0.01	0.01	0.044	0.032
Utilization					
Sum of Emergency Department Visits	3.30	2.95	3.58	0.217	0.070
Sum of Inpatient Admissions	1.64	1.02	1.38	0.015	0.063
Evaluation & Management Services	5.75	5.23	5.20	0.048	-0.005
Mental Health Services	11.70	16.91	22.41	0.221	0.066
Average CDPS Risk Score	1.79	1.88	2.04	0.406	0.081

Source: UCLA analysis of Medi-Cal data, July - September 2019.
Notes: Any serious mental illness included schizophrenia, bipolar disorder, and recurrent depression. CDPS: Chronic Illness and Disability Payment System, measuring the diversity of diagnoses and burden of illness and used here as an indicator of severity.

The characteristics of the WPC enrollee and control group samples show relatively similar proportions overall, with some differences in age, race/ethnicity, and primary language (Exhibit 4). WPC enrollees were somewhat older, had more Asian Americans and Pacific Islanders, and fewer English speakers. In comparison to the WPC enrollees, the matched control group individuals were more often white or Latino and younger.

Exhibit 4: Sociodemographic Characteristics of WPC Final Analytic Samples

	WPC Final Analytic Sample	WPC Enrollees	Control Group
N	277,191	96,450	180,741
Age			
0-18	1.4%	0.9%	1.7%
19-35	32.0%	28.3%	34.0%
36-50	28.4%	28.0%	28.6%
51-64	29.0%	33.6%	26.6%
65+	9.2%	9.2%	9.2%
Race/Ethnicity			
White	31.2%	28.1%	32.9%
Latino	28.7%	23.5%	31.5%
African American	19.3%	25.5%	16.0%
Asian American and Pacific Islander	6.0%	6.3%	5.9%
Native American/Alaska Native	0.9%	0.7%	1.1%
Other	4.9%	6.5%	4.0%
Unknown	8.9%	9.4%	8.6%
Gender			
Male	54.3%	54.7%	54.1%
Female	45.7%	45.3%	45.9%
Language			
English	83.8%	86.8%	82.2%
Spanish	10.8%	8.5%	12.0%
Other[1]	5.4%	4.7%	5.8%
Homelessness			
Yes	7.1%	7.6%	6.8%

Source: UCLA analysis of Medi-Cal data, January to August 2019.
Notes: [1]: Other languages include American Sign Language, Chinese, Japanese, Korean, Vietnamese, Tagalog, Cambodian, Armenian, Ilocano, Mien, Hmong, Lao, Turkish, Hebrew, French, Polish, Russian, Portuguese, Italian, Arabic, Samoan, Thai, Farsi, and other non-English languages.

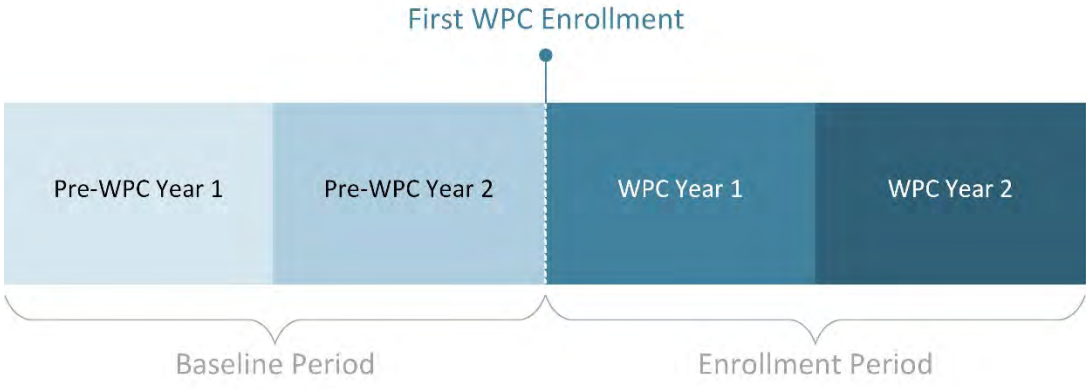
Construction of WPC Universal and Variant Metrics

UCLA constructed the metrics reported by Pilots following the WPC Universal and Variant Metrics Technical Specifications and using the WPC enrollee and control group samples describe above. During WPC, metric specifications occasionally changed to improve measurement accuracy and address various unforeseen challenges. This methodology was consistently applied to both WPC enrollees and control group individuals and therefore was not expected to limit the reliability and validity of the analyses.

These metrics differed from Pilot-reported data for several reasons, including: (1) lack of access to patient-specific information in electronic health records, (2) stratification of the analysis between PY 2 and PY 3 enrollees and (3) use of enrollment year rather than calendar year. Pilots reported one year of baseline, while UCLA used two years of baseline. Pilots also reported baseline values based on Medi-Cal enrollment and used WPC enrollment for reporting years, while UCLA used Medi-Cal enrollment for all years.

For these analyses, UCLA identified pre- and post-WPC enrollment years for each WPC enrollee based on their individual date of first enrollment into WPC. Therefore, baseline periods reflected two years before (Pre-WPC Year 1) and one year before WPC enrollment (Pre-Year 2). The enrollment period included one year after (WPC Year 1) and two years after WPC enrollment (WPC Year 2) (Exhibit 5). When enrollees only had partial data for a 12-month period, the available monthly data was normalized to calculate an annual rate. Partial data for a 12 month time period in the baseline period was due to lack of enrollment in Medi-Cal, and partial data in the intervention period was additionally due to staggered enrollment in WPC.

Exhibit 5: Enrollee-Specific Timeline Based on Date of First WPC Enrollment



These metrics were stratified by the year of enrollment into WPC (PY 2 vs PY 3) to account for differences in enrollee populations but were not adjusted for other enrollee characteristics. Therefore, PY 2 enrollees were observed for two years after enrollment while PY 3 enrollees

were observed for only one year. The lowest and highest Pilot-specific rates were reported to highlight the variation seen between WPC Pilots. Ultimately, 96,868 enrollees with sufficient Medi-Cal data in the baseline and enrollment periods were included in these analyses. Exhibit 6 outlines the universal and variant metrics that UCLA could successfully replicate using Medi-Cal data.

Exhibit 6: Universal and Variant Metrics Replicated Using Medi-Cal Data for Assessing Impact of WPC

Metric Name				
Emergency Department (ED) Visits per 1,000 Member Months	Decrease	For a particular measurement period, the total number of emergency department visits without hospitalization normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Replication of Metric 2.1: Ambulatory Care - ED Visits.	Used Medi-Cal Enrollment Months instead of WPC Enrollment Months. Measurement year is dependent on an individual's enrollment in WPC, not based on calendar year.
Inpatient Visits per 1,000 Member Months	Decrease	For a particular measurement period, the total number of inpatient visits normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Replication of Metric 2.2: Inpatient Utilization - General Hospital/Acute Care.	Used Medi-Cal Enrollment Months instead of WPC Enrollment Months. Measurement year is dependent on an individual's enrollment in WPC, not based on calendar year.
Follow-up after Hospitalization for Mental Illness	Increase	**30-Day Follow-Up:** A follow-up visit with a mental health practitioner within 30 days after or on the date of the discharge. **7-Day Follow-Up:** A follow-up visit with a mental health practitioner within 7 days after or on discharge. **Denominator**: Number of discharges with a principal diagnosis of mental illness experienced by the eligible population between the 1st day of the 1st month and 1st day of the 12th month of the measurement year.	Replication of Metric 2.3: Follow-up after Hospitalization for Mental Illness	Measurement year is dependent on an individual's enrollment in WPC, not based on calendar year.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Increase	**Numerator:** The number of eligible population who initiated treatment or who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug (AOD) dependence. **Denominator:** The number of individuals in the eligible population with a new episode of AOD during the Intake Period.	Replication of Metric 2.4: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Measurement year is dependent on an individual's enrollment in WPC, not based on calendar year.
All-Cause Readmission	Decrease	**Numerator:** At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date. **Denominator:** The number of acute inpatient stays experienced by the eligible population between the 1st day of the 1st month and 1st day of the 12th month of the measurement year.	Replication of Metric 3.1.1: All-Cause Readmissions	Measurement year is dependent on an individual's enrollment in WPC, not based on calendar year.

UCLA further created other metrics that were similar to DHCS specified metrics but could not be constructed due to limitations of using claims data. These additional metrics, the rationale for their creation, and the numerator and denominators used are indicated in Exhibit 7.

Exhibit 7: Additional Metrics for Assessing the WPC Population

Metric Name			
Ever Had an Emergency Department (ED) Visit	Decrease	**Numerator:** All patients who ever had an emergency department visit without hospitalization in a given year. **Denominator:** All patients enrolled in Medi-Cal, in the given measurement period.	Related to Metric 2.1: Ambulatory Care - ED Visits.
ED Visits with a Mental Health Disorder Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of emergency department visits without hospitalization with a mental health disorder diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.1: Ambulatory Care - ED Visits.
ED Visits with a Substance Use Disorder Diagnosis per	Decrease	For a particular measurement period, the total number of emergency department visits without hospitalization with a substance use disorder diagnosis normalized by the total number of	Related to Metric 2.1: Ambulatory Care - ED Visits.

1,000 Member Months		Medi-Cal enrolled member months, multiplying the result by 1,000.	
ED Visits with a Hypertension Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of emergency department visits without hospitalization with a hypertension diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.1: Ambulatory Care - ED Visits.
ED Visits with a Diabetes Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of emergency department visits without hospitalization with a diabetes diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.1: Ambulatory Care - ED Visits.
ED Visits with an IP Admission per 1,000 Member Months	Decrease	For a particular measurement period, the total number of ED to inpatient visits normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.1: Ambulatory Care - ED Visits.
Ever Had an Inpatient (IP) Admission	Decrease	**Numerator:** All patients who ever had an inpatient admission in a given year. **Denominator:** All patients enrolled in Medi-Cal, in the given measurement period.	Related to Metric 2.2: Inpatient Utilization - General Hospital/Acute Care.
Inpatient Visits with a Mental Health Disorder Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of inpatient visits with a mental health diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.2: Inpatient Utilization - General Hospital/Acute Care.
Inpatient Visits with a Substance Use Disorder Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of inpatient visits with a substance use disorder diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.2: Inpatient Utilization - General Hospital/Acute Care.
Inpatient Visits with a Hypertension Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of inpatient visits with a hypertension diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.2: Inpatient Utilization - General Hospital/Acute Care.
Inpatient Visits with a Diabetes Diagnosis per 1,000 Member Months	Decrease	For a particular measurement period, the total number of inpatient visits with a diabetes diagnosis normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Related to Metric 2.2: Inpatient Utilization - General Hospital/Acute Care.
Primary Care Visits per 1,000 Member Months	Increase	For a particular measurement period, the total number of primary care visits normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Change in patterns of primary care delivery.

Specialty Care Visits per 1,000 Member Months	Increase	For a particular measurement period, the total number of specialty care visits normalized by the total number of Medi-Cal enrolled member months, multiplying the result by 1,000.	Change in patterns of specialty care delivery.

Difference-in-Difference Analyses

The DD analyses assessed changes in the average metrics before and during WPC, and in contrast to the control group. The average metrics during baseline and enrollment were compared in order to minimize the impact of high utilization during the period of enrollment due to the enrollment strategies used by WPC Pilots. The baseline and enrollment periods for each WPC enrollee were based on their individual date of enrollment, and the sample included only WPC enrollees with at least two years of baseline data and at least one month of enrollment in WPC. These restrictions resulted in a sample of 1,327,914 person-year observations (290,601 individuals), which included 48,387 WPC enrollees with 1 to 12 months and 48,480 with 13 to 24 months of WPC enrollment. For each Med-Cal enrollee in the control group paired with a WPC enrollee, the enrollment date for the WPC enrollee was used to define the periods before and during enrollment. As an example, for a WPC enrollee who was enrolled on 3/01/2017 until 12/31/2018, the baseline period was 1/01/2015 to 2/28/2017, and the period of enrollment was 3/01/2017 to 12/31/2018. For the control group individual paired with this WPC enrollee, the baseline period and enrollment period were the same.

Different DD models were developed for different metrics due to variations in requirements of sample size and whether they were binary or continuous metrics. The model for binary metrics was as follows:

$$\log[logit(y_{it})] = \alpha_{ig} + \lambda\, WPC\ Enrollee + \gamma \sum_{t=-2}^{1} PY_t + \beta \sum_{t=0}^{1} WPC\ Enrollee * PY_t + \theta X_i \quad (1)$$

For count outcomes, we estimated the following model:

$$\log[E(y_{it})] = \alpha_{ig} + \lambda\, WPC\ Enrollee + \gamma \sum_{t=-2}^{1} PY_t + \beta \sum_{t=0}^{1} WPC\ Enrollee * PY_t + \theta X_i \quad (2)$$

$$\alpha_{ig} = \tau + \eta_g + \ \epsilon_{ig}, \eta_g \sim N(\eta, \nu)\ \epsilon_{ig} \sim N(\mu, \sigma)$$

For these regression models, y_{it} represents outcome variables for patient i at PY t. X_i is the vector of patient-level variables, including age, gender, race/ethnicity (White, Asian and Pacific Islander, Black, Latino, Native American, Other, and Unknown), homelessness indicator, primary language (English, Spanish, and Other), Chronic Illness and Disability Payment System (CDPS) scores, number of enrollment months in Medi-Cal, a dummy variable indicating whether patients enrolled in WPC in 2017 or 2018, and propensity score weights obtained from the matching procedures. α_{ig} denotes the random effect at the individual level and group level for controlling the correlation within individuals and within matched groups.

UCLA used random effect logit models for binary metrics (e.g., 2.3: Follow-Up After Hospitalization for Mental Illness, 2.4: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment) and random effect count model with Poisson distribution for count metrics (e.g., 2.1: Ambulatory Care – ED Visits, 2.2: Inpatient Utilization – General Hospital/Acute Care.). The exposure option was used to adjust for different number of months of Medi-Cal enrollment and the subsequent different lengths of enrollment in WPC. All analyses of individual-level metrics were analyzed based on Medi-Cal member months.

Limitations

The DD analyses had the following limitations. Given the longitudinal nature of the data, patient characteristics such as age, managed care enrollment, and chronic conditions varied over time. UCLA used the first year of WPC enrollment to indicate these characteristics to reduce the complexity of models. In addition, administrative data lacked information on some target populations such as justice-involved, which may have led to some error in pairing WPC enrollees to a patient in the control group. Similarly, administrative data generally lack information on reasons for high service use or other social and contextual reasons. However, the propensity score matching model addressed these limitations to a significant degree.

Although we aimed to achieve a 1:2 ratio analytic sample, with 1 WPC enrollee matched with 2 control individuals, due to the limitations of the control pool and sampling with replacement, we have achieved 1:1.82 ratio, where some control individuals were used multiple times to match to multiple treatment individuals. This would violate the independence assumption across individuals. However, the degree of this overlap is limited, since almost 80% of the time, the individuals were independent of each other. Additionally, the current model has treated the matched group variable (defined as clusters of a WPC enrollee and its matched control individuals) as a random effect, taking into account the correlation within the matched group.

The DD results are not directly comparable to Pilot-reported metrics because the samples were different from those used by Pilots, DD results were adjusted for patient characteristics, and the annual timeframes were based on enrollment rather than calendar year. In addition, the baseline periods in the DD analyses was longer from the baseline periods used by Pilots, potentially bringing more differences between the DD results

Appendix B: Data and Analysis Methods for Self-Reported Metrics

Overview of Self-Reported Metrics

DHCS required Pilots to regularly report on fifteen DHCS-defined metrics to track progress in better care and better outcomes for WPC enrollees. All Pilots participating in WPC were required to report on a specific subset of five metrics, called "universal metrics" that were collected from all Pilots. The universal metrics were: (1) Ambulatory Care Emergency Department Visits per 1,000 WPC Member months; (2) Inpatient Utilization per 1,000 WPC Member Months; (3) Follow-Up After Hospitalization for Mental Illness; (4) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and (5) Comprehensive Care Plan completion.

DHCS also required Pilots to select at least four additional metrics out of the remaining ten metrics, called "variant metrics." Some Pilots changed their variant metrics during WPC implementation due to data collection challenges or changes to strategies or target populations.

Under WPC, progress in metrics was compared after enrollment to the baseline period. For quantitative health care utilization metrics, DHCS designated PY 1 as the baseline period and Pilots gathered this data retrospectively for individuals who were enrolled in the first 18 months of WPC enrollment (1/1/2017 to 6/30/2018). For these metrics, progress was measured starting in PY 2. For other quantitative metrics, the baseline period was PY 2 for individuals who were enrolled in the first 18 months of WPC enrollment to allow Pilots to gather this data. For these metrics, progress was measured starting in PY 3.

Data Source

UCLA analyzed Pilot-reported metrics from the *Annual WPC Variant and Universal Metric Reports* reported to DHCS. Data included the rate and the numerator and denominator used to calculate that rate, for each metric annually. A limited number of metrics were also reported semi-annually, but these data were not included in the analysis.

Methods

UCLA calculated the weighted average for each metric by summing the numerators and the denominators separately for all Pilots that reported data, and then dividing the overall numerator by the overall denominator. Pilots may not have reported data if they had limited enrollment during the measurement period or had other constraints on data availability. When the Pilot reported zero or no values, UCLA examined the reports to determine if the Pilot did not report the metric at all, or if the numerator was zero. UCLA excluded Pilots from the analyses who did not report a value.

UCLA calculated the weighted averages by Pilots that selected each primary target populations. For the analyses of weighted average by Pilots' primary target populations, Pilots who reported homeless and at-risk-of-homelessness targets were combined because their enrollees had similar needs and would receive similar services. Pilots with multiple primary target populations were included in more than one analyses.

UCLA also calculated the weighted average for metrics among Pilots with a pay for outcome (P4O) incentive to improve a similar performance metric. For these analyses, Pilots were classified into those who selected the metric for P4O and those that did not.

Detailed Methods by Self-Reported Metric

This section describes the details of the methods that Pilots used to calculate each of the fifteen self-reported metrics, and includes:

- An overview of the metric and any sub-metrics.
- Measurement specifications, including the numerator and the denominator.
- The baseline period, baseline population, and frequency of reporting.
- A summary of Pilot attributes and whether they reported on this metric in each year.

The details in this section are based on the *Whole Person Care Universal and Variant Metrics Technical Specifications Guide* revised by DHCS on March 22, 2019, and on the *WPC Variant and Universal Metrics Report* spreadsheet that included instructions for Pilots regarding how to report on the universal and variant self-reported metrics.

1. Variant Metric: Control Blood Pressure

Pilots reported the percent of enrollees whose blood pressure was adequately controlled during the measurement year. Three sub-metrics were reported: (1) the percent of enrollees with hypertension age 18-59, whose blood pressure was less than 140/90 mm Hg, (2) the percent of enrollees with hypertension age 60-85 with a diagnosis of diabetes, whose blood pressure was less than 140/90 mm Hg, and (3) the percent of enrollees with hypertension age 60-85 without a diagnosis of diabetes, whose blood pressure was less than 150/90 mm Hg. This metric was modeled on the HEDIS Controlling High Blood Pressure metric. However, the official HEDIS measure was revised in 2019, after implementation of data collection for WPC, and no longer distinguishes between the three groups based on age and diabetes status.

For each of the three sub-metrics, Pilots calculated the percent of enrollees with controlled blood pressure by dividing a numerator (number with controlled blood pressure) by a denominator (number in the group). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were of the appropriate age and diabetes status for each of the three sub-metrics, and had at least one outpatient visit with a diagnosis of hypertension during the first six months of the measurement year. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of members in the denominator whose most recent blood pressure (both systolic and diastolic) was adequately controlled. This most recent blood pressure reading must have occurred after the diagnosis of hypertension. If multiple blood pressure measurements occurred on the same date, or were noted in the chart on the same date, then the lowest systolic and lowest diastolic blood pressure readings were used. If no blood pressure was recorded during the measurement year, then the enrollee was assumed to have uncontrolled blood pressure.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 1: Pilot Attributes and Reporting for Variant Metric: Control Blood Pressure

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					✓	✓	NR-A
Contra Costa		✓							
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓							
Mendocino				✓			✓	✓	✓
Monterey	✓						✓	✓	✓
Napa	✓								
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓				
Riverside			✓				✓	NR-A	✓
Sacramento	✓	✓							
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓							
San Francisco	✓								
San Joaquin	✓	✓		✓					
San Mateo		✓							
Santa Clara		✓							
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓				
Solano		✓		✓					
Sonoma	✓			✓					
Ventura		✓					✓	NR-A	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

2. Variant Metric: Incarcerations per 1,000 Member Months

Pilots reported the number of incarcerations per 1,000 member months. Two sub-metrics were reported: (1) the number of incarcerations per 1,000 member months for those age 14 or older as of June 30 of the measurement year, mainly reported in mid-year reports, and (2) the number of incarcerations per 1,000 member months for those age 14 or older as of December 31 of the measurement year, mainly reported in annual reports. Because this analysis focused on annual data, only the second sub-metric was included in this report.

Pilots calculated the incarceration rate by dividing a numerator by a denominator, and multiplying the result by 1,000. The denominator consisted of a count of member months for all individuals enrolled in WPC at any time during the measurement year. Member months were based on WPC enrollment rather than Medi-Cal enrollment. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the total number of incarcerations experienced by those in the denominator population; one enrollee could have multiple incarcerations during the reporting period.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported twice per year, once for the sub-metric that included those age 14 or older as of June 30 of the measurement year, and again for the sub-metric that included those age 14 or older as of December 31 of the measurement year.

Exhibit 2: Pilot Attributes and Reporting for Variant Metric: Incarcerations per 1,000 Member Months

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓							
Contra Costa		✓							
Kern	✓	✓	✓						
Kings				✓	✓	✓	✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓		✓	✓	✓
Marin	✓	✓							
Mendocino				✓					
Monterey	✓								
Napa	✓								
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓				
Riverside			✓				✓	✓	✓
Sacramento	✓	✓							
San Bernardino		✓							
San Diego	✓	✓					✓	NR-E	✓
San Francisco	✓						✓	✓	✓
San Joaquin	✓	✓		✓			✓	✓	✓
San Mateo		✓							
Santa Clara		✓							
Santa Cruz				✓	✓				
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓				
Solano		✓		✓					
Sonoma	✓			✓			NR-E	NR-E	✓
Ventura		✓							

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

3. Variant Metric: Overall Beneficiary Health

Pilots reported the percent of enrollees that provided a self-reported rating of their health as "Excellent" or "Very Good." Two sub-metrics were reported: (1) the percent of enrollees reporting "Excellent" or "Very Good" overall health, and (2) the percent of enrollees reporting "Excellent" or "Very Good" emotional health. This metric was constructed from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

For each of the two sub-metrics, Pilots calculated the percent of enrollees who rated their health as "Excellent" or "Very Good" by dividing a numerator (number that reported those levels of health) by a denominator (number that answered the survey questions). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year, who were enrolled a total of six months in WPC during the measurement year with multiple allowable gaps. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of responses with answers of "Excellent" or "Very Good," and was calculated separately for overall health and for mental or emotional health.

Unlike other WPC metrics, the baseline reporting period for this metric was calendar year 2017 rather than 2016. This is because data on this metric could not be gathered before WPC enrollment began. This metric was reported annually.

Exhibit 3: Pilot Attributes and Reporting for Variant Metric: Overall Beneficiary Health - Overall Health

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					Not Reported in PY 1		
Contra Costa		✓						✓	✓
Kern	✓	✓	✓			✓			
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓				✓		NR-E	✓
Mendocino				✓					
Monterey	✓								
Napa	✓					✓		NR-A	✓
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓				
Riverside			✓					✓	✓
Sacramento	✓	✓						✓	✓
San Bernardino		✓						✓	✓
San Diego	✓	✓							
San Francisco	✓								
San Joaquin	✓	✓		✓					
San Mateo		✓							
Santa Clara		✓							
Santa Cruz				✓	✓				
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓				
Solano		✓		✓					
Sonoma	✓			✓					
Ventura		✓							

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

Exhibit 4: Pilot Attributes and Reporting for Variant Metric: Overall Beneficiary Health - Emotional Health

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					Not Reported in PY 1		
Contra Costa		✓						✓	✓
Kern	✓	✓	✓			✓			
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓				✓		NR-E	✓
Mendocino				✓					
Monterey	✓								
Napa	✓					✓		NR-A	✓
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓				
Riverside			✓					✓	NR-A
Sacramento	✓	✓						✓	✓
San Bernardino		✓						✓	✓
San Diego	✓	✓							
San Francisco	✓								
San Joaquin	✓	✓		✓					
San Mateo		✓							
Santa Clara		✓							
Santa Cruz				✓	✓				
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓				
Solano		✓		✓					
Sonoma	✓			✓					
Ventura		✓							

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

4. Variant Metric: Comprehensive Diabetes Care

Pilots reported the percent of enrollees age 18 to 75 who had either Type 1 or Type 2 diabetes, who had controlled Hemoglobin A1c (HbA1c), with a value of less than 8.0%. Both types of diabetes were combined into this single metric. This metric closely followed the HEDIS measure for Comprehensive Diabetes Care, CDC-H8. According to DHCS specifications, WPC Pilots were expected to use both claim/encounter and pharmacy data to identify enrollees with diabetes for this metric, although an enrollee only had to be identified as having diabetes through one of the two methods to be included.

Pilots calculated the percent of enrollees with controlled HbA1c by dividing a numerator (number with controlled HbA1c) by a denominator (number with diabetes). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were age 18 to 75 as of December 31 of the measurement year, and had a diagnosis of Type 1 or Type 2 diabetes during the measurement year or the year prior to the measurement year. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of members in the denominator whose most recent HbA1c test during the measurement year showed a level less than 8.0%. If no HbA1c test was conducted during the measurement year, then the enrollee was assumed to have uncontrolled HbA1c.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 5: Pilot Attributes and Reporting for Variant Metric: Comprehensive Diabetes Care

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓							
Contra Costa		✓							
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓	✓	✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓							
Mendocino				✓			✓	✓	✓
Monterey	✓						✓	✓	✓
Napa	✓								
Orange	✓			✓			NR-A	✓	NR-A
Placer	✓	✓	✓	✓	✓				
Riverside			✓				✓	NR-A	✓
Sacramento	✓	✓							
San Bernardino		✓				✓	✓	✓	✓
San Diego	✓	✓							
San Francisco	✓								
San Joaquin	✓	✓		✓			✓	✓	✓
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓							
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓		✓	✓	✓
Solano		✓		✓					
Sonoma	✓			✓					
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

5. Variant Metric: Depression Remission at 12 Months

Pilots reported the percent of enrollees age 18 or older with major depression or dysthymia who reached remission measured at 12 months, plus or minus 30 days, after an index visit. One single metric was reported. This metric closely followed the Minnesota Community Measurement metric for depression care.

Pilots calculated the percent of enrollees with depression remission at 12 months by dividing a numerator (number who reached remission) by a denominator (number age 18 or older with a diagnosis of depression). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were of the appropriate age, and who had an index visit that met all of the following criteria: face-to-face visit or contact with a relevant provider, PHQ-9 result greater than 9, an active diagnosis of major depression or dysthymia, and no prior index visit during the measurement year. Enrollees were excluded from the denominator if they had an active diagnosis of bipolar disorder or personality disorder, if they were a permanent nursing home resident during the measurement year, if they used hospice services or a hospice benefit during the measurement year, or if they died prior to the end of the measurement year. The numerator consisted of the number of members in the denominator who had a PHQ-9 result of less than five, 12 months (plus or minus 30 days) after an index visit, assessed from December 2 prior to the measurement year through January 30 of the year after the measurement year.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 6: Pilot Attributes and Reporting for Variant Metric: Depression Remission at 12 Months

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					✓	✓	NR-A
Contra Costa		✓					✓	✓	✓
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓					NR-A	NR-A	✓
Mendocino				✓					
Monterey	✓						NR-A	✓	✓
Napa	✓								
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓		NR-A	NR-A	✓
Riverside			✓				✓	✓	✓
Sacramento	✓	✓							
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓							
San Francisco	✓								
San Joaquin	✓	✓		✓					
San Mateo		✓							
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓		✓	NR-A	✓
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓		✓	✓	✓
Solano		✓		✓					
Sonoma	✓			✓					
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

6. Variant Metric: Major Depressive Disorder - Suicide Risk Assessment

Pilots reported the percent of enrollees age 18 or older with a diagnosis of major depressive disorder (MDD) who had a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. One single metric was reported. This metric closely followed the suicide risk assessment measure endorsed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement, also adopted by the Federal Electronic Clinical Quality Improvement (eCQI) Resource Center.

Pilots calculated the percent of enrollees who received a suicide risk assessment by dividing a numerator (number that received an assessment) by a denominator (number with major depression). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were of appropriate age and had a diagnosis of major depressive disorder (MDD). The numerator consisted of the number of members in the denominator who had a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 7: Pilot Attributes and Reporting for Variant Metric: Major Depressive Disorder - Suicide Risk Assessment

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					✓	✓	NR-A
Contra Costa		✓					✓	✓	✓
Kern	✓	✓	✓				✓	✓	✓
Kings				✓	✓		✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓		✓	✓	✓
Marin	✓	✓				✓	NR-A	✓	✓
Mendocino				✓			✓	✓	✓
Monterey	✓						✓	✓	✓
Napa	✓					✓	NR-A	NR-A	✓
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓		NR-A	✓	✓
Riverside			✓				✓	✓	✓
Sacramento	✓	✓							
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓					✓	NR-A	✓
San Francisco	✓						✓	✓	✓
San Joaquin	✓	✓		✓			✓	✓	✓
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓			✓	NR-E	✓
Shasta	✓	✓		✓	✓		✓	✓	✓
Solano		✓		✓			NR-A	NR-A	✓
Sonoma	✓			✓			✓	NR-E	✓
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

7. Variant Metric: Permanent Housing

Pilots reported the percent of enrollees who were initially homeless, and then were permanently housed for longer than six consecutive months. One single metric was reported. This metric was created by DHCS.

Pilots calculated the percent of enrollees who were permanently housed for longer than six months by dividing a numerator (homeless enrollees who reached a seven-month time point in housing) by a denominator (homeless enrollees who reached a six-month time point in housing). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were initially homeless, and who reached a six-month time point in permanent housing between December 1 of the prior year and November 30 of the measurement year. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of members in the denominator who reached the seven-month time point in permanent housing between January 1 and December 31 of the measurement year.

Unlike other WPC metrics, the baseline reporting period for this metric was calendar year 2017 rather than 2016. This is because data on this metric could not be gathered before WPC enrollment began. This metric was reported annually.

Exhibit 8: Pilot Attributes and Reporting for Variant Metric: Permanent Housing

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓				✓	Not Reported in PY 1	NR-E	✓
Contra Costa		✓							
Kern	✓	✓	✓						
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓	✓		✓	✓
Marin	✓	✓							
Mendocino				✓					
Monterey	✓							✓	✓
Napa	✓					✓		NR-E	✓
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓				
Riverside			✓					NR-E	✓
Sacramento	✓	✓						NR-E	✓
San Bernardino		✓							
San Diego	✓	✓						NR-E	✓
San Francisco	✓							✓	✓
San Joaquin	✓	✓		✓					
San Mateo		✓							
Santa Clara		✓							
Santa Cruz				✓	✓				
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓			NR-E	✓
Solano		✓		✓				✓	NR-A
Sonoma	✓			✓					
Ventura		✓							

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

8. Variant Metric: Housing Services

Pilots reported the percent of enrollees who were homeless, and who received housing services after being referred to housing services. One single metric was reported. This metric was created by DHCS.

Pilots calculated the percent of enrollees who received housing services after being referred by dividing a numerator (number who received services) by a denominator (number referred to services). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were referred for housing services between January 1 and December 31 of the measurement year; these services were limited to those received after the enrollee's first WPC enrollment date within the measurement year. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of members in the denominator who received housing services after being referred.

Unlike other WPC metrics, the baseline reporting period for this metric was calendar year 2017 rather than 2016. This is because data on this metric could not be gathered before WPC enrollment began. This metric was reported annually.

Exhibit 9: Pilot Attributes and Reporting for Variant Metric: Housing Services

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					Not Reported in PY 1		
Contra Costa		✓							
Kern	✓	✓	✓			✓		✓	✓
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓						✓	✓
Mendocino				✓					
Monterey	✓							✓	✓
Napa	✓								
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓			✓	✓
Riverside			✓					✓	✓
Sacramento	✓	✓				✓		✓	✓
San Bernardino		✓							
San Diego	✓	✓							
San Francisco	✓					✓		NR-TS	NR-TS
San Joaquin	✓	✓		✓				✓	✓
San Mateo		✓				✓		✓	✓
Santa Clara		✓							
Santa Cruz				✓	✓			✓	✓
SCWPCC	✓	✓		✓				✓	✓
Shasta	✓	✓		✓	✓				
Solano		✓		✓		✓			
Sonoma	✓			✓				NR-E	✓
Ventura		✓				✓		✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.
NR-TS: Not reported because Pilot did not follow the technical specifications, resulting in an overestimate of the denominator.

9. Variant Metric: Supportive Housing

Pilots reported the percent of enrollees who were homeless, and who received supportive housing after being referred to supportive housing. One single metric was reported. This metric was created by DHCS.

Pilots calculated the percent of enrollees who received supportive housing after being referred by dividing a numerator (homeless enrollees who received supportive housing) by a denominator (homeless enrollees referred to supportive housing). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were referred for supportive housing between December 1 of the prior year and November 30 of the measurement year; these services were limited to those received after the enrollee's first WPC enrollment date within the measurement year. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of members in the denominator who received supportive housing after being referred.

Unlike other WPC metrics, the baseline reporting period for this metric was calendar year 2017 rather than 2016. This is because data on this metric could not be gathered before WPC enrollment began. This metric was reported annually.

Exhibit 10: Pilot Attributes and Reporting for Variant Metric: Supportive Housing

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					Not Reported in PY 1	✓	✓
Contra Costa		✓							
Kern	✓	✓	✓					✓	✓
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓				
Marin	✓	✓							
Mendocino				✓					
Monterey	✓								
Napa	✓								
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓				
Riverside			✓					✓	✓
Sacramento	✓	✓							
San Bernardino		✓							
San Diego	✓	✓							
San Francisco	✓					✓		NR-TS	NR-TS
San Joaquin	✓	✓		✓					
San Mateo		✓							
Santa Clara		✓						✓	✓
Santa Cruz				✓	✓				
SCWPCC	✓	✓		✓					
Shasta	✓	✓		✓	✓				
Solano		✓		✓				✓	✓
Sonoma	✓			✓					
Ventura		✓							

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.
NR-TS: Not reported because Pilot did not follow the technical specifications, resulting in an overestimate of the denominator.

10. Variant Metric: All-Cause Readmissions

Pilots reported the percent of acute inpatients stays between January 1 and December 1 of the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for enrollees age 21 and older. One single metric was reported. This metric was modeled on the HEDIS Plan All-Cause Readmissions (PCR) metric, with two modifications for WPC. First, for WPC the classification period was reduced from 365 days, 120 days prior to and including the index discharge date. That is, continuous Medi-Cal enrollment was required from 120 days prior to the index discharge date, through 30 days after the index discharge date. Second, the age range was restricted to age 21 and older, excluding those 18 to 20 years old.

Pilots calculated the percent of acute inpatient stays that were followed by a readmission by dividing a numerator (number of discharges followed by a readmission) by a denominator (number of acute inpatient stays). The denominator consisted of a count of index hospital stays for a subset of all individuals age 21 and older who were enrolled in WPC at any time during the measurement year. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. Additionally, index hospital stays for inpatient care were excluded if the admission date was the same as the discharge date, the enrollee died during the stay, the principal diagnosis was pregnancy or a perinatal condition, the principal diagnosis was maintenance chemotherapy, the principal diagnosis was rehabilitation, or the stay was for an organ transplant. The numerator consisted of the number of discharges from the denominator that were followed by at least one acute readmission for any diagnosis within 30 days of the index discharge date.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 11: Pilot Attributes and Reporting for Variant Metric: All-Cause Readmissions

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓							
Contra Costa		✓							
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓				
Los Angeles	✓	✓	✓	✓	✓		✓	✓	✓
Marin	✓	✓							
Mendocino				✓					
Monterey	✓						✓	✓	✓
Napa	✓					✓	NR-E	NR-A	✓
Orange	✓			✓			✓	✓	✓
Placer	✓	✓	✓	✓	✓	✓	✓	✓	✓
Riverside			✓				✓	NR-A	✓
Sacramento	✓	✓				✓	✓	✓	✓
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓							
San Francisco	✓					✓	✓	✓	✓
San Joaquin	✓	✓		✓					
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓			✓	NR-E	✓
Shasta	✓	✓		✓	✓				
Solano		✓		✓			✓	✓	✓
Sonoma	✓			✓			✓	NR-E	✓
Ventura		✓					✓	NR-A	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

11. Universal Metric: Ambulatory Care Emergency Department Visits per 1,000 Member Months

Pilots reported the number of ambulatory care emergency department (ED) visits per 1,000 member months. One single metric was reported. This metric was modeled on the HEDIS Ambulatory Care (AMB) metric. However, while the HEDIS metric included both ambulatory outpatient visits and ED visits, the WPC metric was restricted to only include ambulatory ED visits. Additionally, unlike the HEDIS measure the WPC measure did not exclude visits for mental health or chemical dependency. According to DHCS specifications, this measure was intended to provide a reasonable proxy for professional ambulatory encounters, and was not a strict account of all ambulatory resources or an effort to be all-inclusive.

Pilots calculated the ED visit rate by dividing a numerator by a denominator, and multiplying the result by 1,000. The denominator consisted of a count of member months for all individuals enrolled in WPC at any time during the measurement year. Member months were based on WPC enrollment rather than Medi-Cal enrollment, and no minimum WPC enrollment duration was required to be in the denominator. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the total number of ED visits experienced by those in the denominator population, excluding ED visits that resulted in an inpatient stay (based on an inpatient value set, or in cases when the date of the inpatient stay and the date of the ED visit were one calendar day or less apart); and excluding ED visits for electroconvulsive therapy. Each ED visit was counted once, regardless of its intensity or duration. Multiple ED visits that occurred on the same day were counted as one visit. ED visits were to be identified using an ED value set identified by DHCS.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported twice per year. Pilots included data from the first six months of the measurement year in their mid-year reports, and included data from the full measurement year in their annual reports.

Exhibit 12: Pilot Attributes and Reporting for Universal Metric: Ambulatory Care Emergency Department per 1,000 Member Months

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					✓	✓	✓
Contra Costa		✓					✓	✓	✓
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓		✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓		✓	✓	✓
Marin	✓	✓					✓	✓	✓
Mendocino				✓		✓	✓	✓	✓
Monterey	✓						✓	✓	✓
Napa	✓					✓	NR-E	NR-A	✓
Orange	✓			✓		✓	✓	✓	✓
Placer	✓	✓	✓	✓	✓		✓	✓	✓
Riverside			✓			✓	✓	✓	✓
Sacramento	✓	✓				✓	✓	✓	✓
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓				✓	✓	NR-E	✓
San Francisco	✓					✓	✓	✓	✓
San Joaquin	✓	✓		✓			✓	✓	✓
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓		✓	✓	NR-E	✓
Shasta	✓	✓		✓	✓		✓	✓	✓
Solano		✓		✓			✓	✓	✓
Sonoma	✓			✓			✓	NR-E	✓
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

12. Universal Metric: Inpatient Utilization per 1,000 Member Months

Pilots reported the number of inpatient discharges per 1,000 member months. One single metric was reported. This metric was modeled on the HEDIS Inpatient Utilization-General Hospital/Acute Care (IPU) metric. However, unlike the HEDIS metric, the WPC metric did not exclude mental health and chemical dependency inpatient stays.

Pilots calculated the inpatient utilization rate by dividing a numerator by a denominator, and multiplying the result by 1,000. The denominator consisted of a count of member months for all individuals enrolled in WPC at any time during the measurement year. Member months were based on WPC enrollment rather than Medi-Cal enrollment, and no minimum WPC enrollment duration was required to be in the denominator. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the total number of inpatient discharges experienced by those in the denominator population, excluding those for which the principal diagnosis was of a live-born infant or for newborn care.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported twice per year. Pilots included data from the first six months of the measurement year in their mid-year reports, and included data from the full measurement year in their annual reports.

Exhibit 13: Pilot Attributes and Reporting for Universal Metric: Inpatient Utilization per 1,000 Member Months

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					✓	✓	✓
Contra Costa		✓					✓	✓	✓
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓		✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓		✓	✓	✓
Marin	✓	✓					✓	✓	✓
Mendocino				✓			✓	✓	✓
Monterey	✓						✓	✓	✓
Napa	✓						NR-E	NR-A	✓
Orange	✓			✓		✓	✓	✓	✓
Placer	✓	✓	✓	✓	✓		✓	✓	✓
Riverside			✓				✓	✓	✓
Sacramento	✓	✓				✓	✓	✓	✓
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓				✓	✓	NR-E	✓
San Francisco	✓					✓	✓	✓	✓
San Joaquin	✓	✓		✓			✓	✓	✓
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓		✓	✓	NR-E	✓
Shasta	✓	✓		✓	✓		✓	✓	✓
Solano		✓		✓			✓	✓	✓
Sonoma	✓			✓			✓	NR-E	✓
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

13. Universal Metric: Follow-Up After Hospitalization for Mental Illness

Pilots reported the percent of discharges, for enrollees age 6 and older who were hospitalized for treatment of mental illness, who had a follow-up visit with a mental health practitioner within seven days and within 30 days. Two sub-metrics were reported: (1) the percent of discharges for mental illness for which the enrollee received follow-up within seven days, and (2) the percent of discharges for mental illness for which the enrollee received follow-up within 30 days. This metric was modeled on the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) metric.

For each of the two sub-metrics, Pilots calculated the percent of discharges with timely follow-up by dividing a numerator (number of discharges with timely follow-up) by a denominator (number of discharges with a principal diagnosis of mental illness). The denominator consisted of a count of discharges with a principal diagnosis of mental illness for a subset of all individuals enrolled in WPC at any time during the measurement year. One enrollee could have multiple discharges. Discharges were counted if they were experienced between January 1 and December 1 of the measurement year. Additionally, for the discharge to be included the enrollee had to be continuously enrolled in WPC from the date of discharge through 30 days after discharge. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of discharges in the denominator that had a subsequent follow-up visit with a mental health practitioner within 7 days and 30 days, including visits that occurred on the date of discharge.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 14: Pilot Attributes and Reporting for Universal Metric: Follow-Up After Hospitalization for Mental Illness

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓				✓	✓	✓	✓
Contra Costa		✓					✓	✓	✓
Kern	✓	✓	✓			✓	✓	✓	✓
Kings				✓	✓		✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓		✓	✓	✓
Marin	✓	✓					✓	✓	✓
Mendocino				✓		✓	✓	✓	✓
Monterey	✓					✓	✓	✓	✓
Napa	✓						NR-E	NR-A	✓
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓	✓	✓	✓	✓
Riverside			✓				✓	✓	✓
Sacramento	✓	✓					NR-A	NR-A	✓
San Bernardino		✓					✓	✓	✓
San Diego	✓	✓					✓	NR-E	✓
San Francisco	✓					✓	✓	✓	✓
San Joaquin	✓	✓		✓		✓	✓	✓	✓
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓	✓	✓	✓	✓
SCWPCC	✓	✓		✓			✓	NR-E	✓
Shasta	✓	✓		✓	✓	✓	✓	✓	✓
Solano		✓		✓			NR-A	✓	✓
Sonoma	✓			✓			✓	NR-E	✓
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

14. Universal Metric: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Pilots reported the percent of enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who initiated and engaged in treatment. Two sub-metrics were reported: (1) the percent of enrollees who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis, and (2) the percent of enrollees who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. Data was reported together for adults and youth. This metric was modeled on the HEDIS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) metric.

For each of the two sub-metrics, Pilots calculated the percent of enrollees who initiated and engaged in treatment by dividing a numerator (number that initiated or engaged in treatment) by a denominator (number that received an AOD diagnosis from January 1 through November 15 of the measurement year). The denominator consisted of a subset of all individuals enrolled in WPC at any time during the measurement year who were age 13 and older as of December 31 of the measurement year, who had medical and chemical dependency benefits, and who had a new diagnosis of AOD between January 1 and November 15 of the measurement year. Additionally, to be included, enrollees had to be continuously enrolled in Medi-Cal for 44 days after the index episode start date. Enrollees were excluded from the denominator if they used hospice services or a hospice benefit during the measurement year. The numerator consisted of the number of members in the denominator who initiated treatment within 14 days of AOD diagnosis, or who engaged in two or more additional AOD treatments within 30 days of initiation, depending on the sub-metric. Initiation of treatment was defined as an AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization. Engagement in additional treatment was defined as initiating treatment and having two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

The baseline period consisted of calendar year 2016 (January 1, 2016 through December 31, 2016). Because no one was enrolled in WPC during the baseline period, Pilots defined the baseline population as the cohort that was enrolled in WPC from January 1, 2017 through June 30, 2018, per DHCS specifications. Pilots then gathered Medi-Cal data retrospectively for the baseline year for this enrollee population. This metric was reported annually.

Exhibit 15: Pilot Attributes and Reporting for Universal Metric: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					✓	✓	✓
Contra Costa		✓					NR-A	NR-A	✓
Kern	✓	✓	✓			✓	✓	✓	NR-A
Kings				✓	✓		✓	✓	✓
Los Angeles	✓	✓	✓	✓	✓		NR-A	NR-A	✓
Marin	✓	✓					✓	✓	✓
Mendocino				✓			✓	✓	✓
Monterey	✓						✓	✓	✓
Napa	✓						NR-E	NR-A	✓
Orange	✓			✓					
Placer	✓	✓	✓	✓	✓		✓	✓	✓
Riverside			✓				✓	✓	✓
Sacramento	✓	✓					NR-A	NR-A	✓
San Bernardino		✓					NR-A	NR-A	✓
San Diego	✓	✓					✓	NR-E	✓
San Francisco	✓					✓	NR-A	NR-A	✓
San Joaquin	✓	✓		✓			✓	✓	✓
San Mateo		✓				✓	✓	✓	✓
Santa Clara		✓				✓	✓	✓	✓
Santa Cruz				✓	✓		✓	✓	✓
SCWPCC	✓	✓		✓			✓	NR-E	✓
Shasta	✓	✓		✓	✓		✓	✓	✓
Solano		✓		✓		✓	NR-A	NR-A	✓
Sonoma	✓			✓			✓	NR-E	✓
Ventura		✓				✓	✓	✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

15. Universal Metric: Comprehensive Care Plan

Pilots reported the percent of enrollees who received a comprehensive care plan, accessible by their entire care team, within 30 days of enrollment and within 30 days of the enrollee's anniversary of enrollment in WPC. Two sub-metrics were reported: (1) the percent of enrollees who received a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment, and (2) the percent of enrollees who received a comprehensive care plan, accessible by the entire care team, within 30 days of the enrollee's twelve-month anniversary date of enrollment in WPC. This metric was created by DHCS.

For each of the two sub-metrics, Pilots calculated the percent of enrollees with a comprehensive care plan by dividing a numerator (number with a plan within 30 days of enrollment or anniversary) by a denominator (number of enrollees that were new or had an anniversary). The denominator consisted of the number of enrollees who were either new to WPC, or who had a twelve-month anniversary as an enrollee in WPC, depending on the sub-metric. The numerator consisted of the number of members in the denominator population who had a comprehensive care plan within 30 days of enrollment, or their twelve-month anniversary of enrollment, depending on the sub-metric.

Unlike other WPC metrics, the baseline reporting period for this metric was calendar year 2017 rather than 2016. This is because data on this metric could not be gathered before WPC enrollment began. This metric was reported annually.

Exhibit 16: Pilot Attributes and Reporting for Universal Metric: Comprehensive Care Plan - Within 30 Days of Enrollment

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					Not Reported in PY 1	✓	✓
Contra Costa		✓						✓	✓
Kern	✓	✓	✓			✓		✓	✓
Kings				✓	✓	✓		✓	✓
Los Angeles	✓	✓	✓	✓	✓			✓	✓
Marin	✓	✓						✓	✓
Mendocino				✓				✓	✓
Monterey	✓					✓		✓	✓
Napa	✓							NR-E	✓
Orange	✓			✓		✓		NR-A	NR-A
Placer	✓	✓	✓	✓	✓	✓		✓	✓
Riverside			✓					✓	✓
Sacramento	✓	✓						✓	✓
San Bernardino		✓						✓	✓
San Diego	✓	✓						NR-E	✓
San Francisco	✓							✓	✓
San Joaquin	✓	✓		✓				✓	✓
San Mateo		✓				✓		✓	✓
Santa Clara		✓				✓		✓	✓
Santa Cruz				✓	✓	✓		✓	✓
SCWPCC	✓	✓		✓				NR-E	✓
Shasta	✓	✓		✓	✓			✓	✓
Solano		✓		✓		✓		✓	✓
Sonoma	✓			✓				NR-E	✓
Ventura		✓				✓		✓	✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

Exhibit 17: Pilot Attributes and Reporting for Universal Metric: Comprehensive Care Plan - Within 30 Days of Twelve-Month Anniversary of Enrollment

Pilot	Target Population(s)					Had an Aligned Pay-for-Outcome Metric	Whether Reported on Metric, By Program Year (PY)		
	HL	HU	JI	S	CPC		PY1	PY2	PY3
Alameda	✓	✓					Not Reported in PY 1	Not Reported in PY 2	✓
Contra Costa		✓							✓
Kern	✓	✓	✓			✓			NR-A
Kings				✓	✓	✓			✓
Los Angeles	✓	✓	✓	✓	✓				✓
Marin	✓	✓							✓
Mendocino				✓					✓
Monterey	✓					✓			✓
Napa	✓								✓
Orange	✓			✓		✓			NR-A
Placer	✓	✓	✓	✓	✓	✓			✓
Riverside			✓						✓
Sacramento	✓	✓							✓
San Bernardino		✓							✓
San Diego	✓	✓							NR-E
San Francisco	✓								NR-E
San Joaquin	✓	✓		✓					✓
San Mateo		✓				✓			✓
Santa Clara		✓				✓			✓
Santa Cruz				✓	✓	✓			NR-E
SCWPCC	✓	✓		✓					✓
Shasta	✓	✓		✓	✓				✓
Solano		✓		✓		✓			✓
Sonoma	✓			✓					NR-E
Ventura		✓				✓			✓

Target populations: HL = Homeless or At Risk of Homelessness, HU = High Utilizers, JI = Justice Involved, S = Serious Mental Illness/Substance Use Disorder, CPC = Chronic Physical Condition.
NR-E: Not reported because enrollment or the program did not begin by this period.
NR-A: Not reported because availability of data was limited at this period.

Appendix C: Data and Analysis Methods for Narrative Reports

Data Source

The UCLA evaluation team used data from four rounds of narrative reports (PY 2 mid-year, PY2 annual, PY 3 mid-year, and PY 3 annual) submitted by WPC Pilots to the California Department of Health Care Services. Data in these reports covered January 2017 through December 2018. In these reports, WPC Pilots were asked to report on program achievement, success, and progress as well as on program challenges, barriers, and lessons learned in three major domains: care coordination, data and information sharing, and data reporting. WPC Pilots were also asked to report on outcomes and sustainability of WPC. A complete overview of reporting requirements for these narrative reports can be found in Attachment GG Special Terms and Conditions.

Methods

All narrative reports were reviewed for completeness and imported into the qualitative analysis software NVIVO 12.0. To facilitate analysis, all reports were organized by WPC Pilot. Both inductive and deductive coding methods were applied for analysis. After developing an initial codebook based on sections outlined in the narrative reports (deductive coding), the codebook was subsequently refined to reflect emergent themes in the data (inductive coding) and to eliminate redundancies and repetitions across sections of the report. All narrative reports were coded and reviewed by at least two members of the team, and five primary themes from the initial coding process were identified: (1) care coordination; (2) data and information sharing; (3) identifying, engaging, and enrolling eligible beneficiaries; (4) biggest barriers to WPC success; and (5) WPC outcomes and sustainability. An additional round of coding was conducted to identify and quantify specific subthemes within the data. Only the most prevalent subthemes were included in the interim evaluation report.

Limitations

The qualitative analysis of narrative reports relied on self-reported data from participating WPC Pilots. While efforts were made to validate responses and perspectives within and across the data sources when possible, there is potential for responses to have been subject to response or social desirability bias. Due to the concurrence of WPC with other programs focused on redesign of care processes and payment, the effects of WPC cannot fully be separated from other programs.

Appendix D: Data and Analysis Methods for Lead Entity Survey

Data Source

To gain insight into WPC implementation in the early stages of the program, UCLA administered an interim survey from July-September 2018 to key program staff from Lead Entities (n=27) participating in WPC Pilots.

The survey included 74 closed and open-ended questions on various domains:

- Questions about the local context of the Pilot and motivation for participation;
- Questions about WPC infrastructure, resources and implementation;
- Questions about intra- and inter-agency communication, decision-making and collaborative processes and participation in learning collaboratives;
- Questions about processes developed regarding potential and current WPC enrollees; and
- Questions about program monitoring activities, performance trends and perceived impact of WPC.

The interim Pilot survey assessed health information technology infrastructure, specific activities related to project implementation, ratings of level of effort, staffing and workforce development, participation in quality improvement activities, and challenges and solutions. Questions constituted a variety of structures including yes/no, multiple choice, ranking, Likert scale, and matrix. The survey was pilot-tested among stakeholders at seven Pilots (Contra Costa, Orange, Riverside, Santa Cruz, Shasta, San Bernardino, and San Joaquin) from April to June 2018. Following pilot testing, UCLA revised the structure and content of the survey to address stakeholder feedback before deploying the final version of the survey to all Lead Entities.

Surveys were administered via SurveyMonkey. WPC Pilot contacts at each Lead Entity were emailed a link to complete the survey and were instructed to involve additional team members who were most knowledgeable about implementation of specific WPC domains. Surveys were filled out predominantly by leaders (directors, administrators, and program managers) in each Lead Entity.

The survey instrument is available in Appendix N.

Methods

Data were analyzed using Excel and Stata 12. Descriptive analyses were conducted to assess Lead Entity characteristics on the different survey domains. Members of the team recoded responses to open-ended questions or responses to Likert Scale and matrix questions as needed to appropriate categories.

Limitations

The analysis of the interim Pilot relied on self-reported data from participating WPC Pilots. While efforts were made to validate responses and perspectives within and across the data sources when possible, there is potential for responses to have been subject to response or social desirability bias. Due to the concurrence of WPC with other programs focused on redesign of care processes and payment, the effects of WPC cannot fully be separated from other programs.

Appendix E: Data and Analysis Methods for Follow-up Interviews

Data Source

To gain in-depth understanding of WPC implementation, UCLA conducted semi-structured interviews with key informants from all participating WPC Pilots (n=27). Interviews were conducted from September 2018 to March 2019 and lasted roughly 90 to 120 minutes.

WPC Pilot contacts were asked to include individuals with expertise on the county's WPC implementation and care coordination processes. Each WPC Pilot participated in at least two interviews: one with frontline staff (i.e., care coordinators, Public Health Nurses, frontline supervisors, social workers), and one with key leadership and management (i.e., WPC Directors, project managers). Interviews were conducted in-person with several particularly large and complex Pilot programs as part of site visits, including Los Angeles, Santa Clara, Contra Costa, Alameda, San Francisco, and San Mateo. All other remaining interviews with WPC Pilots were conducted and recorded using Zoom phone conferencing software or handheld audio recorders. Interviews were led by a member of the UCLA evaluation team, with input from additional members, as appropriate. A total of 95 interviews were conducted with 235 individual key informants.

Interviews focused on greater understanding of concepts such as motivation for participation in WPC, communication and decision-making processes, performance monitoring, and inter-agency collaboration with partner organizations. Additional topics included: the general impact of WPC, synergy with other projects, leadership and staff buy-in, recommendations for ongoing implementation of the program, and clarification or expansion upon topics noted in the questionnaire. A key focus of interviews was to gain an in-depth perspective about how WPC had impacted care coordination structure and processes. See Appendix O for the interview protocol used for both frontline staff and Lead Entity interviews.

Methods

Interviews were transcribed verbatim using Rev.com transcription services and de-identified prior to analysis. A codebook was developed based on key evaluation questions and interview content, using both inductive (i.e., based on emergent themes from coding of initial interviews) and deductive coding (i.e., based on a priori themes and components of the interview protocol). After establishing a codebook, the transcribed interviews were distributed among 5 members of the study team for coding analysis. During the coding process, study team

members met regularly to discuss emerging themes and refine the codebook as needed. See Exhibit for the qualitative codebook used for the qualitative analysis. Analyses was completed using NVivo 12 software.

Limitations

Follow-up interviews relied on self-reported data from participating WPC frontline staff and key leadership and management. While efforts were made to validate responses and perspectives within and across the data sources when possible, there is potential for responses to have been subject to response or social desirability bias. Due to the concurrence of WPC with other programs focused on redesign of care processes and payment, the effects of WPC cannot fully be separated from other programs.

Exhibit 1: Codebook Used for Preliminary Coding of Follow-up Interviews

NODES

A. Respondent Role
Who are respondents, how involved in WPC

B. WPC Program and Context
- History, prior initiatives, other context
- Other current programs/ initiatives (Health Homes, etc.) – synergy or competitive overlap
- Motivation for WPC

C. WPC Program
General overview of WPC program & target population

- General Overview
- Target Population

D. WPC Implementation
WPC program changes, implementation policies & practices

E. WPC Leadership & Governance
- LE strategic priorities

F. Partners
Any references to partnership changes, new partnerships as a result of WPC, communication or collaboration with partners.

- **Partner Type**
  1. Managed care plans
  2. Public health
  3. Healthcare
  4. Behavioral health
  5. Housing or social services
  6. Justice Involved
  7. Other

G. Data sharing/ IT Infrastructure: Care Coordination
Any references to data sharing agreements, HIE or other data repository, case management software or other infrastructure for tracking referrals, services, & care coordination efforts, CFR 42

H. Data sharing / IT infrastructure: Reporting
Any references to data sharing / IT infrastructure needed to support reporting / outcome tracking

I. Identifying, enrolling, and engaging eligible clients
- Identifying beneficiaries
- Engaging beneficiaries (incl. outreach)

- Enrollment strategy
- Disenrollment/graduation

J. **Care Coordination**
- Definition of care coordination
- Care coordination elements / how it works (e.g., needs assessment, care plan, referral tracking, case conferences)
- Care Coordinator role / team
- Accountability for care coordination (e.g., supervisorial structure, protocol/standards for CC, referral follow-up, etc.)

K. WPC services and intervention (not care coordination)
- Housing
- Behavioral Health
- Other

L. **Frontline Supervisors and/or Staff**

Any references to recruitment efforts, scope of work, supervisor & staff orientation, supervisor/staff skills & training, etc.

M. **Lessons Learned: Facilitators, Barriers**
- Facilitators / Success Strategies
- Barriers/Challenges

N. WPC Outcomes
- Perceived Impact
- Universal and variant metrics
- Other outcomes
- Unanticipated consequences

O. Internal evaluation activities

P. Technical assistance and UCLA evaluation

Q. Sustainability

R. Misc.

S. Illustrative and Interesting quotes

T. Enrollment and utilization reports

Collections / Sets:

- County/LE
- Legacy, Expansion, New
- Program Size (Target Pop): Small (<=1,000), medium, Large (10,000+)
- Program Structure: Centralized vs. De-centralized
- Program Structure: Some contracted vs. All Contracted vs. Not Contracted
- Cost: Large, medium, small
- Target population: High Utilizers, SMI/SUD, Chronic Physical Conditions, Homelessness and/or At Risk of Homelessness, Justice Involved
- Interview Type: Leadership and Strategy, Frontline Supervisor; Frontline Staff

Appendix F: Data and Analysis Methods for Partner Surveys

Data Source

To gain a comprehensive understanding into WPC implementation, UCLA developed a survey for participating partners from WPC Pilots. The interim partner survey was conducted from July to October 2018 with various types of partner agencies, including community clinics, hospitals, private human and social service providers, county mental health and housing agencies, probation/law enforcement agencies, private mental health and substance abuse agencies as well as other types of county and private agencies. A total of 227 partners from 25 Lead Entities participated in the survey. Partner surveys from two counties were excluded: Plumas withdrew from participation, another delayed implementation due to fires (Sonoma).

The majority of questions in the interim partner survey were identical to questions from the interim Pilot survey. The partner survey included closed and open-ended questions. Questions explored health information technology infrastructure, specific activities related to project implementation, ratings of level of effort, staffing and workforce development, participation in quality improvement activities, changes in collaboration as a result of WPC, and challenges and solutions to project implementation. Questions constituted a variety of structures including yes/no, multiple choice, ranking, Likert scale, and matrix.

Interim partner surveys were conducted via SurveyMonkey. WPC Pilots provided an email link to their partner agencies to complete the survey. Partners were advised to involve additional team members as needed to ensure questions were answered by the person most knowledgeable about specific WPC domains. Surveys were mainly completed by leaders (directors, administrators, and program managers) of the partner agencies. Several Medi-Cal managed care plans who partnered with multiple WPC Pilots completed the survey over the phone with two UCLA evaluation team members in order to reduce respondent burden.

The survey instrument is available in Appendix P.

Methods

Data were analyzed using Excel and Stata 12. Descriptive analyses were conducted to assess partner organization characteristics on the survey domains. Members of the team recoded responses to open-ended questions or responses to Likert Scale and matrix questions as needed to present responses in presentable categories.

Limitations

Interim partner surveys relied on self-reported data from participating partner organizations from WPC Pilots. While efforts were made to validate responses and perspectives within and across the data sources when possible, there is potential for responses to have been subject to response or social desirability bias. Due to the concurrence of WPC with other programs focused on redesign of care processes and payment, the effects of WPC cannot fully be separated from other programs.

Appendix G: Data and Analysis Methods for PDSA Reports

Data Source

WPC Pilots were required to submit Plan Do Study Act (PDSA) reports for Universal and Variant metrics semi-annually and annually in order to report on quality and performance improvements. WPC Pilots were also required to submit a PDSA Pilot summary worksheet. Pilots organized PDSAs into category types that included: (1) ambulatory care, (2) care coordination, (3) comprehensive care plan, (4) data, (5) inpatient utilization, and (6) other.

DHCS provided Pilots with a template for PDSA reporting. WPC Pilots were asked to report the following for each PDSA project: (1) WPC Lead Entity, (2) project lead (name/phone number/email), (3) reporting period, (4) PDSA project, (5) target population, (6) PDSA size, (7) status, (8) PDSA type, (9) start date, (10) recent revision date, (11) report date, (12) project description, (13) revision, (14) results, and (15) next steps.

Methods

PDSAs reports were sent to UCLA by DHCS and reviewed for completeness. UCLA received PDSAs for the following reporting years: PY 2 mid-year, PY 2 annual, PY 3 mid-year, and PY 3 annual. PDSA reports were compiled into Excel and categorized by both Pilot and reporting year. Counts were developed for PDSA type and length of days per PDSA project by PDSA type, Pilot, and reporting year. Counts of PDSA reports were also calculated based on continuity through all reporting periods.

Appendix H: WPC Services Offered through PMPM Bundles and FFS

Methodology

In order to categorize the services reported by WPC pilots into eight common service categories, UCLA used (1) WPC Pilot applications (n=25); (2) key informant follow-up interviews with leadership and frontline staff (n=27); (3) WPC Pilot questionnaires (n=27); and (4) narrative reports submitted to DHCS (n=25). For additional detail on data sources and methodology please see Methods Section.

Pilots had the flexibility to provide services that would best fit the needs of their target populations and could be delivered with the existing infrastructure and resources. Services delivered by Pilots could only be identified through an examination of bundled (PMPM or per member per month) or specific services (FFS or fee-for-service) that Pilots used to report to DHCS and receive payment. Bundled services varied in what combinations of services were included and associated costs, as they were tailored by each Pilot to fit the needs of the population they expected to serve. UCLA examined information from Pilots applications, narrative reports, enrollment and utilization reports, and interviews to identify general categories of services delivered by Pilots. For this analysis, the services by SCWPCC Pilot (San Benito, Plumas, and Mariposa) were analyzed separately as each used different bundles of services.

Eight categories of services were identified using this methodology: (1) Outreach ; (2) Care Coordination; (3) Housing Support; (5) Peer Support; (6) Benefit Support; (7) Employment Assistance; (8) Sobering Center; and (9) Medical Respite. Exhibit 69. For example, Pilots that described providing assistance in accessing and obtaining sustainable housing solutions or financial assistance used to maintain and achieve healthy living situations in a specific bundle or specific service in any of the above sources of data were considered to provide housing support through that bundle or service. Of the services listed, sobering centers, medical respite, and outreach were infrequently included in bundles and therefore most clearly identified. In Exhibit 1, categorization of each PMPM and FFS category is shown along with the rate of each category. The rate was used to calculate the total service cost per enrollee.

Exhibit 1: Service Categories and Cost of PMPM and FFS Categories

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 1	Alameda	Care Management Services Bundle Tier 1		X		X					$ 320.95
PMPM Category 2	Alameda	Care Management Services Bundle Tier 2		X		X					$ 473.96
PMPM Category 3	Alameda	Skilled Nursing Facility Transitions			X						$ 315.39
FFS Category 4	Alameda	Del #8. Housing Education & Legal Assistance - Individual legal assistance			X						$ 1,755.00
PMPM Category 4	Alameda	Enhanced Housing Transition Service Bundle			X						$ 323.73
PMPM Category 5	Alameda	Housing & Tenancy Sustaining Service Bundle			X						$ 210.68
PMPM Category 6	Alameda	Trust Health Center Street Psychiatric Team		X							$ 1,353.00
FFS Category 7	Alameda	Del #14. Sobering Center - Bed days							X		$ 239.21
PMPM Category 7	Alameda	Health, Housing and Integrated Services Bundle Tier 1		X	X	X					$ 300.00
FFS Category 8	Alameda	Del #15. SUD Diversion - Assessment hours		X							$ 229.29
PMPM Category 8	Alameda	Health, Housing and Integrated Services Bundle Tier 2		X	X	X					$ 400.00

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
FFS Category 9	Alameda	Del #15. SUD Diversion - Court visit encounters, hours		X							$ 229.29
PMPM Category 9	Alameda	Health, Housing and Integrated Services Bundle Tier 3		X	X	X					$ 575.00
FFS Category 10	Alameda	Del #15. SUD Diversion - Drug testing w/ Care Manager contact, hours		X							$ 229.29
FFS Category 11	Alameda	Del. #16 Portals to Substance Use Disorder Treatment - Linkage, hours		X							$ 154.99
FFS Category 12	Alameda	Del. #16 Portals to Substance Use Disorder Treatment – helpline, hours		X							$ 154.99
FFS Category 19	Alameda	Del #19. Completed IBH Care Coordination for patients at FQHC		X							$ 102.43
FFS Category 20	Alameda	Del #20b. BH Medical Homes - Nurse Care Coordinators-referrals		X							$ 154.35
FFS Category 25	Alameda	Del #20c. BH Medical Homes - Patient transport referrals		X							$ 131.01
FFS Category 1	Contra Costa	Housing Transition Services FFS			X						$ 4,500.00
PMPM Category 1	Contra Costa	Comprehensive Case Management Tier A		X	X	X	X	X			$ 326.00

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 2	Contra Costa	Comprehensive Case Management Tier B		X	X	X	X	X			$ 146.00
PMPM Category 1	Kern	Housing Navigation			X						$ 480.00
PMPM Category 2	Kern	Employment Services						X			$ 200.00
FFS Category 3	Kern	Benefits Advocacy					X				$ 133.33
PMPM Category 3	Kern	WPC Care Coordination		X	X			X			$ 450.00
FFS Category 4	Kern	Screening Assessment and Referral	X								$ 147.00
PMPM Category 4	Kern	90-Day Post-Incarceration Coordination		X				X			$ 1,800.00
FFS Category 5	Kern	Information and Referral	X								$ 90.00
PMPM Category 5	Kern	Moderate Housing Support			X	X					$ 171.00
FFS Category 1	Kings	Short Term Recuperative Care Unit							X		$ 150.00
PMPM Category 1	Kings	Care Coordination		X		X		X			$ 526.00
FFS Category 2	Kings	Community Integration						X			$ 205.00
PMPM Category 2	Kings	Housing Navigation			X						$ 157.00
FFS Category 3	Kings	Engagement	X								$ 166.00
PMPM Category 3	Kings	Comprehensive Care Coordination/Low Ratio		X		X		X			$ 1,152.00
FFS Category 4	Kings	SSI Advocacy					X	X			$ 2,225.00
FFS Category 1	Los Angeles	Sobering Center							X		$ 260.70
PMPM Category 1	Los Angeles	Benefits Advocacy Services					X				$ 764.02

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 2	Los Angeles	Homelessness Care Support Services		X	X		X	X			$ 514.15
PMPM Category 3	Los Angeles	Tenancy Support Services (TSS)			X						$ 161.66
PMPM Category 4	Los Angeles	Recuperative Care Services		X			X			X	$ 5,909.99
PMPM Category 5	Los Angeles	Psychiatric Recuperative Care Services		X						X	$ 10,940.45
PMPM Category 6	Los Angeles	Justice Re-entry - Adult Jail Referral		X	X	X	X	X			$ 427.56
PMPM Category 7	Los Angeles	Justice Re-entry - Adult Community Referral		X	X	X	X	X			$ 857.70
PMPM Category 8	Los Angeles	Justice Re-entry - Extended Adult Care		X	X	X	X	X			$ 427.56
PMPM Category 10	Los Angeles	Justice Re-entry - Enhanced Care Coordination		X			X				$ 1,458.52
PMPM Category 11	Los Angeles	Intensive Service Recipient (ISR)		X	X	X	X	X			$ 1,030.31
PMPM Category 12	Los Angeles	Residential and Bridging Care		X	X	X	X				$ 2,139.52
PMPM Category 13	Los Angeles	Residential and Bridging Care Enhanced Care Coordination		X	X	X	X				$ 3,044.14
PMPM Category 14	Los Angeles	Substance Use Disorder Engagement, Navigation, and Support (SUD-ENS)		X	X		X	X			$ 615.68
PMPM Category 15	Los Angeles	Medically Complex - Transitions of Care		X	X	X	X				$ 500.68
PMPM Category 16	Los Angeles	Kin to Peer		X		X					$ 1,246.17

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 17	Los Angeles	MAMA's Neighborhood		X		X	X				$ 780.74
FFS Category 1	Marin	Information and Referral	X								$ 90.00
PMPM Category 1	Marin	Comprehensive Case Management		X							$ 270.00
FFS Category 2	Marin	Screening, Assessment, and Referral	X								$ 147.00
PMPM Category 2	Marin	Housing-Based Case Management		X	X	X	X				$ 540.00
FFS Category 3	Marin	Person-centered Care Plan		X							$ 147.00
PMPM Category 3	Marin	Case Management for Individuals with Mild to Moderate Mental Health Conditions and Complex Psycho-social Challenges		X							$ 462.33
FFS Category 4	Marin	Client Move-In Fee			X						$ 2,701.15
FFS Category 1	Mariposa	Outreach & Engagement	X								$ 250.00
PMPM Category 1	Mariposa	Comprehensive Care Coordination		X							$ 1,721.00
FFS Category 2	Mariposa	Respite Care								X	$ 500.00
PMPM Category 2	Mariposa	Housing Navigation and Supports			X						$ 1,389.00
FFS Category 1	Mendocino	Medical Respite Services								X	$ 154.00
PMPM Category 1	Mendocino	High Intensity Coordination Bundle		X		X			X		$ 816.00
FFS Category 2	Mendocino	Mental Health Transitional Support								X	$ 150.00

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 2	Mendocino	Short Term Care Coordination Bundle		X	X				X		$ 564.00
PMPM Category 1	Monterey	Complex Care Management Team		X	X		X				$ 988.75
PMPM Category 2	Monterey	Community-Based Case Management Services		X	X						$ 308.33
FFS Category 3	Monterey	Housing Placement and Support			X	X					$ 77.28
FFS Category 4	Monterey	Targeted Outreach	X								$ 287.58
FFS Category 6	Monterey	Sobering Center Sun Street							X		$ 216.65
FFS Category 8	Monterey	Housing Navigation & Tenancy Support			X						$ 2,575.00
FFS Category 9	Monterey	Rapid Rehousing (CCCIL)			X						$ 2,574.09
FFS Category 10	Monterey	Franciscan Worker Case Management	X								$ 308.33
FFS Category 1	Napa	Number_in_FFS_Category_1: Respite Care (bed nights)								X	$ 115.00
PMPM Category 1	Napa	Mobile Engagement		X	X	X					$ 650.00
PMPM Category 2	Napa	Coordinated Entry Services		X	X						$ 776.00
PMPM Category 3	Napa	Tenancy Care		X	X		X				$ 191.00
PMPM Category 4	Napa	SOAR					X				$ 510.00
FFS Category 5	Napa	Number_in_FFS_Category_5: Community Links		X							$ 729.00
FFS Category 1	Orange	Recuperative Care								X	$ 180.50

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 1	Orange	Hospital & Clinic Homeless Navigation Services		X	X						$ 121.00
PMPM Category 2	Orange	Supportive and Linkage Services provided by Drop-In Center Providers		X	X	X					$ 216.00
PMPM Category 3	Orange	SMI Specific Outreach & Navigation		X	X						$ 207.50
PMPM Category 1	Placer	Comprehensive Complex Care Coordination (CCCC)		X		X	X				$ 1,521.00
PMPM Category 2	Placer	Medical Respite Care Program		X			X			X	$ 8,826.00
PMPM Category 3	Placer	Housing Services			X						$ 1,603.00
PMPM Category 4	Placer	Engagement		X		X					$ 2,112.00
FFS Category 1	Plumas	Outreach & Engagement	X								$ 300.00
PMPM Category 1	Plumas	Comprehensive Care Coordination		X							$ 1,467.00
FFS Category 2	Plumas	Respite Care								X	$ 500.00
PMPM Category 2	Plumas	Housing Navigation and Supports			X						$ 687.00
FFS Category 1	Riverside	Screening/Outreach	X								$ 239.00
PMPM Category 1	Riverside	RN Case Management		X							$ 350.00
FFS Category 2	Riverside	Benefits Advocacy					X				$ 239.00
PMPM Category 2	Riverside	Housing Support Case Management			X						$ 469.00
PMPM Category 1	Sacramento	Housing Bundle			X						$ 375.00

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
FFS Category 2	Sacramento	Outreach and Referral FFS	X								$ 225.00
PMPM Category 2	Sacramento	Higher Intensity Case Management & Navigation Services		X			X				$ 537.00
PMPM Category 3	Sacramento	Lower Intensity Case Management & Navigation Services		X		X	X				$ 282.00
FFS Category 1	San Benito	Outreach & Engagement	X								$ 365.67
PMPM Category 1	San Benito	Comprehensive Care Coordination		X							$ 1,657.00
PMPM Category 2	San Benito	Housing Navigation and Supports			X						$ 1,936.00
FFS Category 1	San Bernardino	Field-based Outreach Activity	X								$ 217.00
PMPM Category 1	San Bernardino	Case Coordination		X	X		X				$ 283.00
FFS Category 1	San Diego	Outreach and Engagement	X								$ 204.00
PMPM Category 1	San Diego	Stabilization		X	X	X	X				$ 851.00
PMPM Category 2	San Diego	Maintenance		X	X	X	X				$ 681.00
FFS Category 1	San Francisco	days in Dual Diagnosis Trmt setting for SUD, MH								X	$ 300.00
PMPM Category 1	San Francisco	Outreach and Engagement services		X	X		X				$ 246.27
FFS Category 2	San Francisco	days in SUD trmt setting for SUD								X	$ 140.00
PMPM Category 2	San Francisco	Care Coordination services		X			X				$ 314.94

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
FFS Category 3	San Francisco	days in Medical Respite for medical conditions								X	$ 134.38
FFS Category 3	San Francisco	days in Medical Respite for medical and psychiatric conditions								X	$ 134.38
PMPM Category 3	San Francisco	Enhanced Housing Transition services			X		X				$ 348.23
FFS Category 4	San Francisco	Resource Center services			X		X				$ 83.35
PMPM Category 4	San Francisco	Housing and Tenancy Stabilization services			X		X				$ 422.16
FFS Category 5	San Francisco	Coordinated Entry Expansion services		X	X						$ 255.36
FFS Category 6	San Francisco	Encampment Response Expansion services			X		X				$ 52.92
FFS Category 7	San Francisco	Outreach and Engagement services	X								$ 16.38
FFS Category 1	San Joaquin	Recuperative Medical Respite and Care Management Services								X	$ 85.00
PMPM Category 1	San Joaquin	Population Health/CMC		X							$ 161.07
FFS Category 2	San Joaquin	Care Coordination		X							$ 56.15
FFS Category 3	San Joaquin	BHS Integration Team		X	X	X					$ 137.00
PMPM Category 1	San Mateo	Bridges to Wellness		X	X	X					$ 636.00
PMPM Category 2	San Mateo	Behavioral Health and Recovery Services		X	X	X	X		X		$ 829.00
FFS Category 1	Santa Clara	Peer Respite				X				X	$ 213.56

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
PMPM Category 1	Santa Clara	Rehabilitation and Peer Support		X		X					$ 137.19
FFS Category 2	Santa Clara	Medical Respite								X	$ 376.02
PMPM Category 2	Santa Clara	Short Term Care Management		X		X					$ 1,220.70
FFS Category 3	Santa Clara	Sobering Station							X		$ 246.12
PMPM Category 3	Santa Clara	Mid Term Care Management		X		X					$ 1,363.54
PMPM Category 4	Santa Clara	Long Term Care Management		X		X					$ 882.88
PMPM Category 5	Santa Clara	Nursing Home Transitions		X	X						$ 2,076.70
FFS Category 1	Santa Cruz	Housing Support			X						$ 4,500.00
PMPM Category 1	Santa Cruz	Behavioral Health Bundle		X							$ 502.24
FFS Category 2	Santa Cruz	Tenancy Support			X						$ 305.63
PMPM Category 2	Santa Cruz	Clinic Health Bundle		X			X				$ 501.15
FFS Category 3	Santa Cruz	Outreach and Referrals	X								$ 175.00
PMPM Category 3	Santa Cruz	Intensive Housing Support Bundle			X						$ 717.53
FFS Category 4	Santa Cruz	Screening, Assessment, and Eligibility	X								$ 300.00
PMPM Category 4	Santa Cruz	Intermediate Housing Support Bundle			X	X					$ 170.63
PMPM Category 1	Shasta	Medical Case Management		X							$ 595.00
PMPM Category 2	Shasta	Housing Case Management		X	X	X					$ 816.41
PMPM Category 1	Solano	Transitional Care Program Plus Bundle		X	X	X	X	X			$ 454.00

Category	WPC Pilot	Category Name	Outreach	Care Coordination	Housing Support	Peer Support	Benefit Support	Employment Assistance	Sobering Center	Medical Respite	Rate
FFS Category 1	Sonoma	Outreach and Engagement Services	X								$ 48.56
PMPM Category 1	Sonoma	Intensive Case Management Bundle		X	X	X	X				$ 1,366.00
FFS Category 1	Ventura	Recuperative Care Program								X	$ 129.47
PMPM Category 1	Ventura	Engagement Bundle		X			X				$ 318.21
FFS Category 2	Ventura	Mobile Outreach Services	X								$ 168.94
PMPM Category 2	Ventura	Care Coordination		X	X		X				$ 269.69
PMPM Category 3	Ventura	Field-based Care Coordination Bundle		X	X		X				$ 223.74

Appendix I: Detailed Unadjusted Universal and Variant Metrics using Medi-Cal Data

UCLA constructed the metrics reported by Pilots following the WPC Universal and Variant Metrics Technical Specifications and using the WPC enrollee and control group samples describe above. These metrics differed from Pilot-reported data for several reasons, including: (1) lack of access to patient-specific information in electronic health records, (2) stratification of the analysis between PY 2 and PY 3 enrollees and (3) reporting of both enrollment year rather and calendar year. Pilots also reported baseline values based on Medi-Cal enrollment and used WPC enrollment for reporting years, while UCLA used Medi-Cal enrollment for all years.

For these analyses, UCLA identified pre- and post-WPC enrollment years for each WPC enrollee based on their individual date of first enrollment into WPC. Therefore, baseline periods reflected (1) two years before (Pre-WPC Year 1) and (2) one year before WPC enrollment (Pre-Year 2). The enrollment period included (1) one year after (WPC Year 1) and (2) two years after WPC enrollment (WPC Year 2) (Exhibit 1). When enrollees only had partial data for a 12-month period, the available monthly data was normalized to calculate an annual rate. Partial data for a 12 month time period in the baseline period was due to lack of enrollment in Medi-Cal, and partial data in the intervention period was additionally due to staggered enrollment in WPC. In Exhibit 2 and Exhibit 3, UCLA reports unadjusted metrics by enrollment year and calendar year for PY 2 and PY 3 enrollees.

Exhibit 1: Enrollee-Specific Timeline Based on Date of First WPC Enrollment

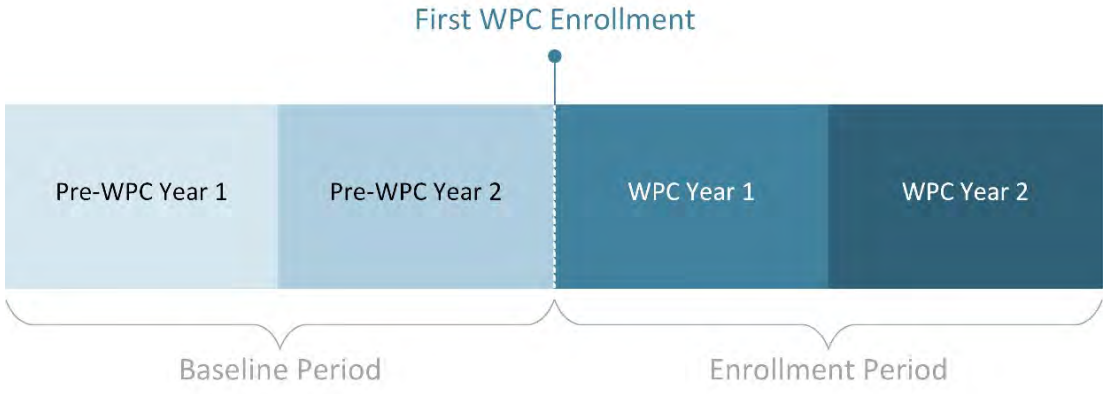


Exhibit 2: Universal Metrics using Medi-Cal Data

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
ED visits without Hospitalization per 1,000 Medi-Cal Member Months															
All WPC	158	189	230	183	169	214	216	181	119	141	171	188	149	188	183
Alameda	195	342	403	323	267	358	396	372	135	211	217	240	206	233	294
Contra Costa	87	78	156	130	89	125	138	129	57	46	83	97	52	104	88
Kern	68	75	96	74	78	82	77	89	116	131	143	147	134	152	136
Kings	94	138	286	142	134	262	182	81	165	233	262	234	289	242	191
Los Angeles	157	194	212	158	173	215	186	137	127	160	195	187	172	206	176
Marin	417	354	304	149	399	286	158	176	130	151	155	170	162	168	174
Mendocino	359	426	295	242	427	249	280	345	177	222	251	236	224	263	226
Monterey	286	422	642	445	333	488	597	451	318	456	486	447	520	531	345
Napa	157	176	227	185	188	184	225	166	190	182	181	193	180	202	177
Orange	186	198	272	228	194	224	276	226	154	164	181	270	168	208	287
Placer	174	195	225	170	181	204	207	156	214	226	282	325	230	326	293

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Riverside	127	139	164	115	149	156	133	18	99	102	104	101	103	106	97
Sacramento	280	202	268	250	214	263	271	145	161	221	281	350	247	324	340
San Bernardino	220	217	205	169	227	199	190	162	152	192	177	162	184	178	149
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	389	374	387	483	371	465	409
San Francisco	253	307	335	268	261	304	342	271	148	160	161	208	160	169	231
San Joaquin	438	775	1004	602	687	991	726	506	301	390	544	594	448	638	501
San Mateo	247	339	257	214	244	345	250	215	162	148	231	249	158	265	229
Santa Clara	168	201	202	181	175	203	201	176	168	182	263	231	222	265	238
Santa Cruz	216	256	379	303	228	326	372	248	184	174	208	245	196	231	230
Shasta	351	471	466	307	401	532	337	324	167	224	301	375	229	370	350
SCWPCC	261	292	333	292	333	250	375	0	279	308	285	456	335	383	409
Solano	361	521	535	443	434	563	471	377	188	301	325	423	303	388	404
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	156	201	231	262	230	249	276

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Ventura	232	352	382	289	314	385	315	277	186	199	267	304	213	289	312
High Utilizers	159	193	255	204	169	231	239	215	108	126	161	184	133	185	170
Homeless	206	255	284	221	221	270	271	216	160	191	215	248	195	232	270
SMI/SUD	243	301	312	257	251	322	299	246	181	206	258	267	225	271	263
At-Risk-of-Homelessness	135	182	223	164	160	211	193	154	136	150	179	182	159	192	198
Chronic Physical Conditions	186	217	237	204	194	229	229	198	152	173	185	204	178	204	199
Justice-Involved	188	248	327	234	228	301	276	225	126	137	149	157	140	166	148
IP Hospitalizations per 1,000 Medi-Cal Member Months															
All WPC	60	67	77	62	61	75	74	59	40	43	52	73	45	62	78
Alameda	98	104	132	95	96	121	125	88	60	69	78	87	72	88	83
Contra Costa	32	36	38	32	29	42	36	31	20	13	19	20	14	22	20
Kern	26	40	51	23	42	49	31	12	17	23	33	30	27	34	27
Kings	13	26	7	19	27	13	13	32	15	21	16	30	18	24	29

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Los Angeles	78	94	111	88	84	108	104	77	50	60	73	119	63	89	132
Marin	135	79	155	68	110	149	66	118	27	30	35	43	34	45	36
Mendocino	34	116	42	42	118	35	42	69	17	20	43	60	22	60	52
Monterey	71	104	136	82	87	135	91	92	41	77	154	107	82	179	83
Napa	20	22	38	50	17	30	50	46	14	16	26	35	22	32	31
Orange	35	43	85	67	40	60	84	64	31	36	53	80	41	62	83
Placer	25	27	41	31	32	38	33	28	25	43	36	87	40	83	51
Riverside	18	21	28	15	25	26	19	0	29	26	29	25	26	29	24
Sacramento	33	42	75	63	38	66	73	57	47	63	89	115	73	104	119
San Bernardino	146	195	131	131	208	143	131	141	55	97	83	88	93	92	80
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	118	154	134	208	140	204	161
San Francisco	74	65	78	72	73	65	81	75	42	35	38	64	37	44	71
San Joaquin	78	82	126	85	82	103	103	129	40	38	69	84	52	81	90

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
San Mateo	123	127	119	59	125	131	112	59	92	76	105	121	81	113	133
Santa Clara	44	59	62	51	46	64	58	49	35	33	61	68	47	71	63
Santa Cruz	46	82	84	60	58	98	67	58	47	36	55	55	40	62	52
Shasta	64	68	101	68	50	99	90	56	36	48	70	140	58	107	127
SCWPCC	43	42	0	125	83	0	125	0	27	74	39	63	83	49	55
Solano	79	189	148	118	130	200	123	131	38	54	96	151	62	116	169
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	32	55	60	73	54	65	83
Ventura	57	87	101	73	78	102	81	61	32	45	71	90	57	81	87
High Utilizers	59	67	74	54	59	74	70	55	37	36	46	55	39	55	48
Homeless	65	71	89	70	68	80	86	65	48	52	66	89	56	76	100
SMI/SUD	86	101	111	74	91	111	104	71	48	51	68	85	53	80	89
At-Risk-of-Homelessness	34	47	66	48	42	59	58	47	31	33	42	50	35	51	50
Chronic Physical Conditions	55	78	78	66	66	80	72	62	40	50	55	69	50	68	67

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Justice-Involved	45	51	54	44	46	54	46	58	28	28	30	33	28	34	32
Follow-Up after Hospitalization for Mental Illness (7 Days)															
All WPC	59%	52%	54%	57%	55%	52%	55%	58%	58%	52%	53%	57%	52%	53%	59%
Alameda	64%	53%	53%	50%	56%	49%	56%	45%	64%	49%	55%	51%	56%	49%	55%
Contra Costa	59%	50%	51%	47%	56%	47%	51%	49%	58%	42%	51%	62%	41%	56%	67%
Kern	NR-D	0%	NR-D	NR-D	0%	NR-D	NR-D	NR-D	57%	50%	38%	33%	50%	29%	33%
Kings	NR-D	60%	NR-D	100%	67%	50%	100%	NR-D	83%	60%	50%	86%	25%	89%	86%
Los Angeles	55%	50%	52%	56%	52%	51%	54%	58%	53%	50%	50%	55%	49%	51%	56%
Marin	0%	100%	50%	0%	100%	50%	0%	0%	54%	62%	53%	66%	60%	56%	88%
Mendocino	50%	67%	60%	80%	71%	33%	86%	0%	100%	50%	61%	81%	45%	70%	83%
Monterey	0%	80%	22%	80%	50%	33%	60%	75%	50%	80%	88%	67%	80%	88%	60%
Napa	50%	33%	67%	50%	100%	0%	67%	67%	50%	0%	43%	50%	50%	40%	NR-D
Orange	55%	62%	60%	64%	57%	64%	62%	61%	64%	61%	56%	62%	61%	57%	64%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Placer	40%	33%	0%	25%	50%	0%	0%	100%	0%	75%	0%	67%	75%	75%	33%
Riverside	75%	67%	50%	33%	100%	43%	33%	NR-D	84%	75%	67%	72%	63%	72%	75%
Sacramento	33%	50%	33%	50%	67%	25%	50%	0%	40%	42%	34%	42%	39%	32%	44%
San Bernardino	70%	54%	50%	47%	56%	52%	46%	50%	71%	51%	56%	51%	54%	55%	49%
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	72%	61%	54%	63%	58%	62%	59%
San Francisco	70%	61%	62%	66%	66%	60%	63%	68%	65%	62%	60%	70%	61%	64%	73%
San Joaquin	62%	46%	57%	33%	60%	57%	40%	0%	75%	24%	68%	55%	51%	70%	36%
San Mateo	65%	57%	61%	65%	64%	57%	61%	66%	47%	70%	61%	63%	65%	61%	67%
Santa Clara	60%	39%	45%	46%	47%	40%	47%	44%	47%	60%	49%	62%	45%	55%	76%
Santa Cruz	57%	55%	53%	57%	64%	49%	58%	42%	54%	58%	52%	47%	67%	48%	50%
Shasta	50%	40%	80%	43%	40%	55%	43%	NR-D	33%	43%	42%	59%	31%	57%	63%
SCWPCC	0%	0%	0%	0%	0%	0%	0%	0%	100%	29%	67%	50%	33%	60%	60%
Solano	NR-D	83%	50%	55%	0%	73%	50%	67%	100%	0%	100%	50%	50%	80%	33%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	75%	63%	79%	68%	71%	71%	74%
Ventura	38%	47%	46%	38%	39%	46%	45%	25%	48%	30%	28%	48%	21%	39%	47%
High Utilizers	64%	53%	54%	53%	58%	52%	55%	55%	65%	51%	54%	56%	52%	54%	58%
Homeless	58%	53%	54%	58%	56%	52%	56%	59%	60%	55%	54%	58%	55%	54%	60%
SMI/SUD	58%	52%	54%	55%	57%	52%	55%	55%	67%	61%	59%	60%	58%	60%	62%
At-Risk-of-Homelessness	45%	49%	48%	53%	51%	47%	50%	54%	74%	66%	67%	64%	62%	66%	66%
Chronic Physical Conditions	64%	46%	49%	51%	52%	46%	50%	50%	68%	51%	57%	56%	52%	57%	54%
Justice-Involved	46%	49%	53%	58%	51%	49%	54%	68%	81%	66%	65%	64%	57%	69%	63%
Follow-Up after Hospitalization for Mental Illness (30 Days)															
All WPC	76%	73%	75%	81%	74%	73%	77%	83%	74%	72%	72%	80%	71%	75%	82%
Alameda	78%	79%	79%	77%	76%	76%	83%	72%	80%	73%	75%	78%	76%	73%	87%
Contra Costa	84%	74%	78%	77%	81%	74%	76%	78%	79%	68%	74%	83%	69%	78%	87%
Kern	NR-D	NR-D	NR-D	NR-D	NR-D	NR-D	NR-D	NR-D	86%	100%	69%	83%	70%	86%	67%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Kings	NR-D	100%	NR-D	100%	100%	100%	100%	NR-D	83%	70%	50%	100%	38%	100%	100%
Los Angeles	72%	69%	72%	80%	69%	71%	74%	83%	71%	68%	70%	77%	68%	72%	79%
Marin	0%	100%	100%	100%	100%	100%	100%	0%	73%	77%	74%	86%	76%	80%	100%
Mendocino	50%	67%	100%	100%	71%	100%	100%	0%	100%	80%	87%	90%	91%	88%	89%
Monterey	0%	100%	33%	80%	50%	44%	80%	75%	50%	100%	100%	67%	100%	100%	60%
Napa	100%	67%	100%	50%	100%	67%	67%	67%	100%	0%	86%	100%	100%	80%	NR-D
Orange	73%	77%	74%	84%	72%	77%	78%	85%	76%	77%	73%	83%	76%	74%	86%
Placer	80%	100%	67%	100%	83%	75%	100%	100%	0%	75%	0%	100%	75%	75%	100%
Riverside	75%	67%	83%	33%	100%	71%	33%	NR-D	89%	80%	78%	91%	71%	85%	96%
Sacramento	56%	80%	67%	83%	78%	69%	80%	0%	50%	62%	57%	78%	53%	70%	77%
San Bernardino	91%	77%	78%	80%	82%	76%	78%	92%	89%	77%	77%	79%	74%	77%	82%
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	83%	86%	79%	82%	83%	84%	76%
San Francisco	84%	79%	80%	84%	81%	78%	81%	86%	75%	79%	76%	87%	77%	81%	90%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
San Joaquin	77%	77%	78%	78%	90%	74%	80%	100%	90%	69%	77%	86%	59%	91%	82%
San Mateo	79%	73%	81%	88%	78%	74%	81%	88%	65%	88%	80%	84%	85%	81%	85%
Santa Clara	79%	72%	81%	86%	77%	73%	83%	90%	65%	80%	77%	86%	79%	82%	88%
Santa Cruz	75%	80%	83%	81%	84%	75%	83%	83%	69%	75%	83%	85%	80%	83%	86%
Shasta	50%	80%	100%	57%	80%	82%	57%	NR-D	67%	57%	58%	88%	54%	79%	88%
SCWPCC	0%	0%	0%	0%	0%	0%	0%	0%	100%	71%	67%	63%	50%	80%	60%
Solano	NR-D	100%	90%	91%	100%	91%	92%	100%	100%	100%	100%	83%	100%	80%	100%
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	91%	90%	92%	90%	89%	92%	92%
Ventura	69%	82%	83%	65%	72%	84%	73%	63%	78%	65%	60%	84%	49%	77%	85%
High Utilizers	81%	76%	80%	80%	79%	77%	80%	82%	81%	74%	76%	81%	73%	78%	85%
Homeless	75%	73%	74%	81%	72%	73%	77%	84%	74%	72%	70%	79%	71%	73%	81%
SMI/SUD	75%	73%	78%	82%	74%	73%	80%	86%	80%	78%	78%	83%	76%	80%	83%
At-Risk-of-Homelessness	67%	67%	70%	79%	67%	69%	73%	85%	82%	79%	81%	84%	74%	85%	84%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Chronic Physical Conditions	84%	76%	77%	80%	80%	75%	78%	82%	81%	72%	79%	80%	71%	80%	81%
Justice-Involved	58%	70%	65%	76%	71%	62%	73%	82%	87%	78%	76%	86%	72%	84%	86%
Initiation of Alcohol and Other Drug Dependence Treatment															
All WPC	37%	43%	44%	46%	41%	44%	47%	49%	37%	42%	44%	47%	42%	46%	53%
Alameda	42%	45%	47%	49%	45%	46%	53%	49%	37%	43%	39%	39%	41%	38%	50%
Contra Costa	30%	33%	32%	38%	30%	34%	36%	43%	31%	29%	33%	36%	30%	36%	41%
Kern	33%	33%	22%	38%	38%	22%	38%	50%	47%	37%	43%	49%	41%	46%	59%
Kings	25%	56%	36%	56%	56%	56%	50%	67%	44%	48%	46%	48%	38%	57%	57%
Los Angeles	41%	48%	51%	47%	45%	50%	52%	48%	41%	46%	50%	52%	48%	51%	57%
Marin	42%	58%	62%	45%	50%	62%	58%	0%	27%	30%	40%	51%	34%	49%	54%
Mendocino	29%	58%	58%	64%	50%	58%	55%	100%	18%	36%	37%	53%	32%	43%	57%
Monterey	46%	52%	48%	65%	50%	41%	67%	57%	42%	63%	50%	79%	62%	56%	80%
Napa	48%	36%	37%	40%	41%	39%	35%	46%	29%	38%	42%	34%	37%	36%	49%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Orange	31%	41%	42%	47%	41%	40%	48%	55%	33%	37%	41%	44%	39%	41%	50%
Placer	23%	39%	32%	55%	34%	32%	38%	59%	24%	44%	36%	54%	46%	48%	46%
Riverside	25%	33%	68%	51%	37%	61%	60%	100%	36%	42%	50%	61%	47%	58%	66%
Sacramento	35%	38%	49%	43%	40%	40%	40%	66%	38%	41%	41%	47%	38%	49%	50%
San Bernardino	44%	44%	50%	44%	43%	46%	52%	49%	38%	42%	40%	39%	44%	41%	39%
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	33%	61%	42%	53%	43%	51%	48%
San Francisco	39%	45%	46%	49%	43%	46%	49%	53%	38%	43%	44%	48%	43%	49%	53%
San Joaquin	45%	51%	43%	42%	50%	33%	45%	74%	36%	44%	46%	48%	49%	47%	51%
San Mateo	37%	42%	40%	45%	37%	41%	42%	45%	36%	47%	46%	59%	42%	47%	60%
Santa Clara	31%	43%	44%	42%	40%	40%	46%	45%	35%	38%	46%	47%	40%	52%	51%
Santa Cruz	27%	48%	47%	53%	42%	43%	45%	60%	23%	37%	38%	46%	43%	50%	59%
Shasta	35%	32%	36%	49%	31%	40%	31%	44%	24%	29%	31%	40%	31%	38%	45%
SCWPCC	0%	0%	0%	0%	0%	0%	0%	0%	29%	33%	41%	38%	32%	45%	40%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Solano	45%	50%	40%	32%	29%	54%	36%	44%	32%	26%	38%	37%	28%	47%	53%
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	39%	40%	42%	40%	38%	38%	45%
Ventura	33%	42%	44%	45%	36%	49%	53%	59%	48%	47%	50%	52%	49%	56%	59%
High Utilizers	36%	42%	42%	45%	38%	41%	46%	48%	36%	39%	39%	43%	39%	41%	51%
Homeless	38%	45%	46%	48%	43%	45%	49%	51%	37%	43%	45%	50%	44%	48%	56%
SMI/SUD	36%	44%	45%	49%	41%	43%	48%	50%	34%	43%	45%	54%	44%	51%	57%
At-Risk-of-Homelessness	38%	43%	47%	47%	43%	45%	50%	51%	31%	40%	47%	54%	42%	52%	58%
Chronic Physical Conditions	32%	44%	44%	45%	40%	43%	47%	49%	35%	42%	44%	50%	44%	49%	55%
Justice-Involved	31%	45%	47%	51%	41%	42%	49%	63%	36%	41%	49%	60%	45%	57%	63%
Engagement of Alcohol and Other Drug Dependence Treatment															
All WPC	19%	20%	22%	25%	**20%**	20%	26%	29%	21%	20%	22%	23%	20%	23%	29%
Alameda	24%	26%	28%	33%	27%	25%	33%	29%	25%	25%	22%	22%	24%	20%	29%
Contra Costa	17%	15%	14%	20%	15%	14%	19%	25%	20%	17%	19%	22%	20%	21%	29%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Kern	33%	17%	22%	25%	25%	22%	25%	50%	34%	26%	26%	32%	22%	29%	50%
Kings	25%	22%	18%	44%	11%	33%	40%	67%	19%	18%	15%	19%	5%	21%	25%
Los Angeles	19%	18%	22%	21%	18%	19%	24%	21%	19%	17%	20%	21%	17%	22%	25%
Marin	33%	42%	46%	18%	42%	31%	42%	0%	13%	10%	22%	32%	17%	29%	36%
Mendocino	0%	33%	50%	64%	25%	50%	55%	83%	5%	14%	15%	33%	9%	22%	38%
Monterey	23%	29%	28%	30%	28%	27%	29%	50%	11%	37%	31%	50%	38%	33%	44%
Napa	27%	23%	23%	21%	24%	20%	22%	29%	15%	21%	23%	15%	17%	20%	27%
Orange	13%	17%	16%	20%	18%	17%	21%	28%	14%	15%	19%	16%	15%	18%	21%
Placer	15%	15%	21%	32%	19%	16%	26%	41%	11%	19%	23%	34%	24%	27%	37%
Riverside	25%	24%	55%	36%	26%	45%	33%	100%	18%	21%	33%	44%	29%	41%	49%
Sacramento	14%	18%	17%	24%	21%	19%	21%	48%	21%	18%	19%	20%	20%	22%	24%
San Bernardino	22%	9%	15%	21%	7%	14%	20%	29%	19%	12%	12%	18%	14%	13%	20%
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	21%	24%	18%	24%	17%	15%	25%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
San Francisco	24%	25%	28%	32%	26%	26%	31%	37%	26%	27%	29%	30%	26%	31%	35%
San Joaquin	24%	22%	22%	24%	26%	17%	19%	58%	21%	22%	23%	25%	24%	23%	31%
San Mateo	17%	20%	21%	29%	17%	20%	23%	29%	16%	26%	18%	36%	23%	21%	38%
Santa Clara	15%	18%	20%	24%	18%	16%	24%	25%	14%	15%	15%	21%	9%	26%	39%
Santa Cruz	15%	22%	21%	39%	18%	18%	26%	43%	13%	24%	19%	33%	24%	31%	40%
Shasta	19%	14%	7%	12%	17%	11%	9%	19%	3%	8%	6%	12%	9%	9%	20%
SCWPCC	0%	0%	0%	0%	0%	0%	0%	0%	12%	17%	24%	29%	14%	25%	20%
Solano	10%	18%	20%	18%	13%	12%	32%	25%	21%	17%	7%	18%	16%	19%	22%
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	23%	17%	18%	13%	19%	16%	17%
Ventura	24%	23%	25%	27%	22%	21%	32%	36%	39%	25%	28%	30%	27%	33%	39%
High Utilizers	19%	20%	21%	26%	19%	19%	25%	28%	21%	21%	21%	24%	21%	21%	31%
Homeless	20%	22%	25%	27%	22%	22%	27%	31%	21%	21%	24%	26%	21%	26%	32%
SMI/SUD	17%	20%	23%	27%	19%	20%	26%	31%	17%	20%	23%	29%	21%	27%	34%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
At-Risk-of-Homelessness	19%	20%	23%	23%	19%	22%	25%	25%	15%	18%	26%	34%	24%	30%	39%
Chronic Physical Conditions	15%	18%	20%	24%	17%	17%	23%	27%	17%	18%	21%	29%	20%	25%	34%
Justice-Involved	19%	17%	24%	32%	15%	20%	29%	41%	17%	20%	31%	40%	25%	37%	45%

Source: Medi-Cal Enrollment and Claims data from 2015 to 2018

Notes: NR-E: Not reported because enrollment or the program did not begin by this period.

NR-D: Denominator equals zero, no rate reported

Exhibit 3: Variant Metrics using Medi-Cal Data

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
All-Cause Readmission															
All WPC	14%	17%	19%	17%	16%	18%	20%	17%	13%	16%	16%	18%	15%	17%	18%
Alameda	12%	19%	15%	18%	14%	18%	16%	18%	10%	14%	14%	17%	14%	14%	19%
Contra Costa	9%	8%	10%	12%	9%	8%	12%	12%	9%	7%	9%	8%	9%	8%	8%
Kern	0%	10%	26%	8%	11%	24%	14%	0%	20%	9%	11%	16%	12%	12%	13%
Kings	0%	0%	NR-D	NR-D	0%	NR-D	NR-D	NR-D	0%	0%	0%	28%	0%	24%	9%
Los Angeles	21%	28%	30%	22%	24%	29%	29%	19%	17%	22%	21%	25%	21%	23%	25%
Marin	0%	25%	33%	0%	17%	33%	0%	0%	11%	8%	9%	8%	9%	9%	0%
Mendocino	0%	0%	0%	0%	0%	0%	0%	NR-D	6%	4%	7%	18%	4%	16%	11%
Monterey	20%	6%	9%	8%	14%	14%	7%	0%	0%	14%	17%	14%	15%	16%	14%
Napa	11%	14%	12%	7%	9%	15%	11%	8%	0%	8%	11%	9%	11%	6%	8%
Orange	11%	16%	22%	20%	17%	18%	22%	20%	12%	14%	15%	18%	14%	16%	18%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Placer	0%	18%	11%	16%	20%	5%	21%	11%	21%	14%	17%	18%	20%	16%	13%
Riverside	25%	0%	0%	0%	0%	0%	0%		2%	9%	8%	11%	5%	12%	10%
Sacramento	21%	0%	13%	20%	7%	10%	18%	0%	13%	16%	19%	18%	18%	18%	15%
San Bernardino	28%	25%	23%	15%	28%	19%	19%	22%	15%	11%	11%	16%	11%	15%	11%
San Diego	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	21%	28%	31%	29%	29%	32%	24%
San Francisco	15%	15%	19%	19%	15%	15%	19%	19%	11%	12%	11%	16%	12%	14%	15%
San Joaquin	23%	31%	24%	34%	32%	18%	36%	42%	13%	13%	16%	17%	14%	16%	14%
San Mateo	9%	18%	17%	14%	9%	18%	16%	14%	16%	10%	17%	20%	12%	18%	18%
Santa Clara	11%	14%	17%	18%	13%	15%	15%	17%	13%	11%	18%	20%	17%	15%	21%
Santa Cruz	4%	17%	15%	17%	11%	17%	19%	15%	15%	26%	23%	23%	23%	20%	24%
Shasta	8%	7%	16%	13%	0%	17%	15%	8%	12%	8%	16%	18%	14%	14%	18%
SCWPCC	0%	0%	NR-D	0%	0%	NR-D	0%	NR-D	14%	18%	7%	13%	21%	12%	0%
Solano	20%	20%	15%	22%	31%	18%	6%	38%	13%	18%	14%	19%	15%	11%	25%

Pilots	PY 2 Enrollees								PY 3 Enrollees						
	Calendar-Year Annual Rates				Enrollment-Year Annual Rates				Calendar-Year Annual Rates				Enrollment-Year Annual Rates		
	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	2015	2016 (PY 1)	2017 (PY 2)	2018 (PY 3)	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1
Sonoma	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	NR-E	7%	17%	20%	13%	18%	15%	9%
Ventura	15%	20%	22%	23%	17%	25%	21%	21%	18%	10%	22%	21%	13%	19%	22%
High Utilizers	13%	15%	16%	17%	14%	15%	17%	17%	12%	14%	14%	16%	14%	14%	15%
Homeless	16%	18%	21%	19%	16%	20%	21%	18%	14%	17%	18%	20%	17%	19%	19%
SMI/SUD	14%	18%	20%	18%	16%	19%	19%	18%	12%	16%	18%	19%	16%	18%	18%
At-Risk-of-Homelessness	16%	17%	18%	17%	17%	18%	17%	17%	9%	11%	16%	18%	12%	17%	16%
Chronic Physical Conditions	14%	17%	18%	18%	17%	17%	17%	20%	15%	16%	16%	20%	16%	18%	19%
Justice-Involved	16%	14%	16%	13%	13%	19%	16%	7%	6%	11%	11%	14%	8%	14%	12%

Source: Medi-Cal Enrollment and Claims data from 2015 to 2018
Notes: NR-E: Not reported because enrollment or the program did not begin by this period.
NR-D: Denominator equals zero, no rate reported

Appendix J: Pilot Primary Target Populations and Reporting

Exhibit 1 provides an overview of the primary target populations by WPC Pilot. Each Pilot developed and defined their own target population(s). Primary target populations were defined as those groups that each Pilot aimed to directly influence and designed their services to address the specific needs of these groups.

Exhibit 1: Primary Target Population by Pilot

WPC Pilot	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Alameda	X			X		
Contra Costa	X					
Kern	X			X	X	X
Kings		X	X			
Los Angeles	X	X	X	X	X	X
Marin	X			X	X	
Mariposa (SCC)	X		X			
Mendocino			X			
Monterey				X		
Napa				X	X	
Orange			X	X		
Placer	X	X	X	X	X	X
Plumas (SCC)			X	X		
Riverside						X
Sacramento	X			X		
San Bernardino	X					
San Benito (SCC)	X			X	X	
San Diego	X			X	X	
San Francisco				X		
San Joaquin	X		X	X	X	
San Mateo	X					
Santa Clara	X					
Santa Cruz		X	X			
Shasta	X					
Solano	X		X			
Sonoma			X	X	X	
Ventura	X					

Source: Key Informant Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019.

In Exhibit 2, the target populations of individual enrollees identified by each Pilot in their quarterly *Enrollment and Utilization Reports* are listed. Due to enrollee privacy issues, Pilots had to identify at least 10 individuals in a target populations to be listed below.

Exhibit 2: Enrollee Target Populations Used by WPC Pilot, January 2017 to December 2018

WPC Pilot	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-Risk of Homelessness	Justice-Involved
Alameda	X			X		
Contra Costa	X			X		
Kern	X	X	X	X	X	X
Kings		X	X			X
Los Angeles	X	X	X	X	X	X
Marin	X			X	X	
Mendocino	X	X	X	X	X	X
Monterey	X	X	X	X	X	
Napa				X		
Orange	X	X	X	X	X	
Placer	X	X	X	X	X	X
Riverside	X	X	X	X	X	X
Sacramento	X	X	X	X	X	
San Bernardino	X	X				
San Diego	X	X	X	X	X	X
San Francisco	X		X	X		
San Joaquin	X		X	X	X	X
San Mateo	X		X	X		
Santa Clara	X	X	X	X		
Santa Cruz	X	X	X	X	X	X
Shasta	X	X	X	X	X	
SCWPCC	X	X	X	X	X	X
Solano	X	X	X	X	X	
Sonoma	X	X	X	X	X	
Ventura	X			X		
Total	**23**	**17**	**19**	**23**	**16**	**10**

Source: *Whole Person Care Enrollment and Utilization Reports* (n=25), January 2017-December 2018.
Notes: Includes 108,667 unique individuals. Includes 246 enrollees who enrolled at two Pilots without cross enrollment. Excludes cross-enrollment. Excludes individuals who received outreach or other WPC services but did not enroll. Excludes 15,392 individuals without target population. When count for a target population was less than 11 individuals, it was not included. SMI/SUD is severe mental illness and/or substance use disorder.

In the following section, we describe the original target population of each WPC Pilot as described in their application, updates to the target population after implementation as described by Pilot leadership in UCLA-led interviews and the target populations of individual

enrollees identified in *Enrollment and Utilization Reports.* We also describe UCLA's ultimate determination of each Pilot's primary target population(s).

Alameda's Target Populations

Description from Application

In their application, the Alameda County Health Care Services Agency (HSCA) identified the target populations of their WPC Pilot as three primary groups:

1. Care Coordination Population – Individuals with complex conditions who may be receiving care management in one system, but actually need care coordination that crosses multiple systems.
2. High Users of Multiple Systems – Medi-Cal beneficiaries who have come in contact with at least two of the following systems: medical, mental health, substance abuse treatment or criminal justice. Individuals are identified using data from the managed care plan, Alameda Alliance for Health, and Alameda County Behavioral Health Care Services.
3. Homeless Persons – Medi-Cal beneficiaries who meet at least one of the Housing and Urban Development (HUD) category definitions of homelessness.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Alameda County HCSA indicated that their target populations included individuals that are on Medi-Cal and had a history of homelessness in the past two years, high utilizers of multiple systems, and Medi-Cal beneficiaries already in a care management program (full-service partnerships). UCLA determined that the primary target populations for Alameda were high utilizers and the homeless.

Pilot Reporting of Target Populations by Enrollee

In *WPC Enrollment and Utilization Reports,* Alameda only reported individuals in two target populations: high utilizers and homeless. These target populations aligned with the primary target populations of their Pilot (Exhibit 3).

Exhibit 3: Alameda WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X			X		
Pilot's Primary Target Populations	X			X		

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Contra Costa's Target Populations

Description from Application

In their application, Contra Costa Health Services indicated that their target population was "Medi-Cal recipients who are primarily and repeatedly accessing health care services in high-acuity settings due to the complexity of their unmet medical, behavioral health and social needs." More specifically, the Pilot used data to identify individuals with the following in one year: skilled nursing facility stay, more than six ED visits, more than six inpatient days or more than two inpatient admissions. They aimed to use their data warehouse to develop a data-driven, real-time algorithm to identify individuals that meet the target population criteria.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Contra Costa indicated that they developed a sophisticated predictive risk model that included information from a variety of county sources. These data sources included information on a potential enrollee's service utilization, chronic conditions, justice involvement and social determinants of health. Contra Costa's primary target population was solely high utilizers to provide enrollment flexibility.

Pilot Reporting of Target Populations by Enrollee

In Contra Costa's enrollment and utilization reports, they reported WPC enrollees in one target population: high utilizers. Given that their predictive risk model aimed to identify individuals that were high utilizers or are at-risk of becoming a high utilizer, their individual reporting aligns with their primary target population (Exhibit 4).

Exhibit 4: Contra Costa WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X					
Pilot's Primary Target Populations	X					

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Kern's Target Populations

Description from Application

In their application, Kern Medical Center (KMC) identified their target population as high utilizers, defined as high utilizers of emergency and inpatient services, with a focus on individuals that are homeless, at-risk of homelessness or have been recently incarcerated. Additionally, all enrollees were required to be eligible for Medi-Cal. The local health plans were supposed to provide lists of individuals that met these criteria.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, KMC indicated that changes to their target populations occurred due to changes in their program. The original intention was to identify high utilizers through lists provided by the two local health plans. However, KMC identified several limitations to this method, including:

- Homeless individuals and those at-risk of homelessness were not identified or captured by the health plans.
- Soon-to-be-released or recently incarcerated individuals were not captured by the health plans.
- The contact information provided by the health plans was typically not current or effective.

As a result, KMC modified their outreach and recruitment process to include referrals from the Housing Authority, in addition to the placement of a physician within jail that identified soon-to-be-released inmates for inclusion in the program. KMC also created a website and email address that allowed for self-referral into the program. As a result, the target population no longer required individuals to be high utilizers - if need was identified through these other recruitment mechanisms, the individual was enrolled. As a result, UCLA identified the primary target population for Kern as high utilizers, homeless, at-risk-of-homelessness and justice-involved.

Pilot Reporting of Target Populations by Enrollee

Through access to several data sources, including behavioral health data and social determinant assessments, KMC was able to assess enrollees for all target populations identified by the State. This included target populations that were targeted by the Pilot (high utilizers, homeless, at-risk-of-homelessness and justice-involved) and target populations not directly targeted by the Pilot (chronic physical conditions and SMI/SUD; Exhibit 5).

Exhibit 5: Kern WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations	X			X	X	X

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Kings' Target Populations

Description from Application

Kings Area Resource Enhanced Linkages (KARELink) aimed to reduce the number of adults with mental illnesses and co-occurring substance use disorders in their jails and to build a collaborative bridge to wellness for people with behavioral health issues who are homeless or at-risk of homelessness. The target population had to have a substance use disorder, mental health issue or chronic health condition of diabetes or high blood pressure.

In their application, Kings County Human Services Agency (KINGS HSA) indicated that their primary target population was the high cost, high utilizers of services who accessed care primarily on a crisis basis via an emergency room or did not access care on an ongoing basis and were often incarcerated. Individuals had to have at least one of the following:

1. Substance use disorder
2. Mental health issue
3. Chronic health conditions (diabetes or hypertension)

Changes during WPC and Primary Target Population Determination

Through UCLA structured interviews, KARELink leadership indicated that their target population was primarily SMI/SUD with chronic physical conditions. High utilizers and justice-involved were a subset of this population, but were not required for enrollment. As a result, UCLA determined their primary target populations to include SMI/SUD and chronic physical conditions.

Pilot Reporting of Target Populations by Enrollee

Initially, KARELink reported on four target populations: high utilizers, chronic physical conditions, SMI/SUD and justice-involved (Exhibit 6). After some changes to their reporting process, they were no longer reporting on high utilizers and justice-involved. The data used to determine an enrollee's target population came from the screening and assessment of the client by care coordinators.

Exhibit 6: Kings WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X (100%)			X
Pilot's Primary Target Populations		X	X			

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Los Angeles' Target Populations

Description from Application

In their application, Los Angeles County Department of Health Services identified six target populations for their WPC Pilot: 1) individuals experiencing homelessness, 2) justice-involved individuals or 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. There was an overlap between the populations and where they did not overlap they still shared similar traits, including difficulty engaging into programs and common challenges to manage debilitating social inequities. Therefore, individuals could enter through any target population.

The homeless target population included all homeless or at-risk of homelessness individuals that were chronically homeless, had a physical or mental disability, had two or more chronic medical or behavioral health (e.g., mental health or substance use disorder) conditions, or were recent and/or recurrent care utilizers (e.g., multiple emergency department (ED) visits or hospitalizations for medical or psychiatric issues).

The justice-involved target population included justice system-involved individuals who were at the highest risk of medical, psychiatric, and/or substance use decompensation with one or more of the following: 1) recent or recurrent acute care utilization, 2) multiple and/or complex chronic medical conditions, 3) serious mental illness, 4) substance use disorders, or 5) pregnancy.

The mental health target population criteria varied depending on the program through which the enrollee were identified. For the Intensive Service Recipient (ISR) program, individuals must have had a severe mental health diagnosis and a minimum of six psychiatric hospital admissions in the previous year. For the Residential and Bridging Care (RBC) program, individuals must have had a serious mental illness and/or co-occurring substance use disorders in psychiatric inpatient units, or exited Institutions of Mental Disease (IMDs) and have been treated in enriched residential settings. For the Kin to Peer (KTP) program, individuals must have lacked family or healthy social support systems and have been eligible for the ISR or RBS programs.

The substance use disorder target population had to have a substance use disorder and at least one of the following: 1) three or more ED visits related to SUD within in the past year, 2) two or more inpatient admissions for physical and/or mental health conditions, 3) three or more sobering center visits within the past year, 4) homeless (meeting HUD criteria), 5) part of foster system, 6) more than two residential SUD treatment admission within the past year, 7) history

of two or more incarcerations with drug use, 8) drug court referral (to either Sentence Defender Court or Women's Re-Entry Court, and/or 9) history of overdose in the past two years.

The medically complex target population consisted of individuals with the Transitions of Care (TOC) program who were admitted to a Lanterman-Petris-Short (LPS) Act general acute care hospital who were on the LANES (Los Angeles Network for Enhanced Services) HIE with three or more admissions (medical or psychiatric) within the last six months and at least one of the following: 1) one or more avoidable hospital admissions related to a chronic medical problem, 2) homelessness, 3) SUD, 4) mental health disorder, and/or 5) incarceration within the last month.

The expectant mothers target population included pregnant women with one or more of the following: 1) homeless or at-risk of homelessness, 2) physical or mental disability, 3) chronic medical or behavioral health condition, 4) soon to be or recently released from incarceration.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Los Angeles indicated that target populations remained as described in the application. As a result, UCLA determined Los Angeles' primary target populations included all six standardized target population groups.

Pilot Reporting of Target Populations by Enrollee

Los Angeles' WPC Pilot reported on all six target populations identified by DHCS (Exhibit 7). In order to determine who was reported in each target population, they used data collected on target populations and homeless status from different programs in the pilot. If target populations information was unavailable, they determined enrollee's status based on program enrollment. For example, all individuals in the sobering centers were included in the SMI/SUD target population and all individuals in the re-entry programs were included in the justice-involved target population.

Exhibit 7: Los Angeles WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations	X	X	X	X	X	X

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Marin's Target Populations

Description from Application

In their application, County of Marin's Department of Health and Human Services (Marin HHS) focused on two target populations:

1. Individuals who experienced homelessness or were at-risk of homelessness (including those released from institutions) and
2. Individuals who experienced complex medical conditions, behavioral health issues, and/or lacked social supports that interfered with standards of care, which resulted in high utilization and costs.

More specifically, the latter population included the top 10% of Medi-Cal beneficiaries by spending who had a diagnosis of a mental disorder, substance use disorder, traumatic brain injury, dementia or opioid use, two or more chronic conditions, and/or repeated incidents of avoidable emergency use, hospital admissions or nursing facility placement.

Changes during WPC and Primary Target Population Determination

Through UCLA interviews with Pilot leadership, Marin HHS indicated that their target population had expanded to include three groups. These groups were linked to their per-member-per-month (PMPM) bundles that provided care coordination. The homeless target population received housing based case management. The high utilizers received comprehensive case management. Lastly, individuals with a mental illness, substance use disorder and/or other health conditions that were not eligible for specialty Medi-Cal mental health plans received case management for individuals with mental health conditions and complex psychosocial challenges. As a result, UCLA identified their primary target populations as high utilizers, homeless and at-risk-of-homelessness.

Pilot Reporting of Target Populations by Enrollee

In enrollment and utilization reports, Marin HHS reported on three target populations: high utilizers, homeless and at-risk of homelessness (Exhibit 8). The high utilizer target population aligned with the complex Med-Cal beneficiary population. The homeless and at-risk of homelessness populations aligned with the homeless target population. The third target population that aimed to address individuals with mental health conditions and complex psycho-social challenges often did not meet the SMI/SUD criteria because those with SMI could be eligible for specialty Medi-Cal mental health plans.

Exhibit 8: Marin WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X			X	X	
Pilot's Primary Target Populations	X			X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Mariposa's Target Populations

Description from Application

In their application, Mariposa County Human Services Department indicated that their target population would be individuals with a behavioral health condition (mental health, substance abuse or co-occurring diagnosis) and one or more of the following:

- Repeated incidents of emergency department (ED) use, hospital admissions or nursing facility placement
- Two or more chronic conditions
- Homeless or at-risk of homelessness
- Recently released from institutions (e.g., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system.

Changes during WPC and Primary Target Population Determination

During UCLA structured interviews, Mariposa indicated that their target population had evolved through implementation. Their focus shifted to high users of the ED due to the small size of the local ED (four beds). Their target population was then defined as high utilizers (three or more ED visits or one hospital admission per year) who had SMI/SUD and any of the following: homelessness, chronic conditions or justice-involved. As a result, UCLA identified their primary target populations as high utilizers and SMI/SUD.

Pilot Reporting of Target Populations by Enrollee

While Mariposa reported on all six of the DHCS-designated target populations, the focus of their program was high utilizers and SMI/SUD (Exhibit 9). In order to determine a potential enrollee's utilization and SMI/SUD status they used data from the managed care plan in addition to self-report and observation.

Exhibit 9: Mariposa WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations	X		X			

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Mendocino's Target Populations

Description from Application

In their application, Mendocino County Health and Human Services Agency (HHSA) indicated that their target population would be individuals with a SMI. They would prioritize high utilizers of mental health and/or medical services and those who experienced homelessness or housing instability, co-occurring SUD and/or recent interactions with the criminal justice system. In addition, enrollees needed to be eligible for Medi-Cal.

Changes during WPC and Primary Target Population Determination

Through structured interviews, UCLA determined that the target population for Mendocino County HHSA was still individuals with SMI, but in order to prioritize enrollees, they also required that enrollees fit into at least two other DHCS-defined target population groups: homeless, at-risk of homelessness, high utilization and justice involvement. UCLA determined their primary target population was SMI/SUD.

Pilot Reporting of Target Populations by Enrollee

In their enrollment and utilization reports, Mendocino County HHSA reported on all target populations except for chronic physical conditions (Exhibit 10). All of their enrollees were in the SMI/SUD target population. Because self-report was the data source for their target population, it is likely errors occurred in the target populations. Additionally different agencies had different methodologies for reporting which resulted in inconsistencies among their population.

Exhibit 10: Mendocino WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X		X	X	X	X
Pilot's Primary Target Populations			X			

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Monterey's Target Populations

Description from Application

The Monterey County Health Department aimed to target homeless and chronically homeless Medi-Cal beneficiaries or Medi-Cal eligible individuals, which included those recently released from jail. Potential enrollees had to have two or more of the following:

- Two or more mental health unit admissions in the prior year,
- Two or more chronic health diagnoses
- Two or more ED visits within the past 12 months,
- One or more hospital admission within the prior 12 months or,
- Two or more prescribed medications (antidepressants, antipsychotics, mood stabilizers, diabetes medication, antihypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators, seizure medications and anticoagulants).

More specifically, Monterey County intended to use the HUD McKinney-Vento Homeless Assistance Act definition of homeless and the 2016 HUD Hearth definition of chronically homeless.

Changes during WPC and Primary Target Population Determination

Through UCLA interviews with Pilot leadership, Monterey County Health Department indicated that after implementation, they continued to focus on homeless individuals. They did not provide services to individuals that were at-risk of homelessness, rather they needed to already be living on the streets to receive services. The majority of the enrollees were also high-utilizers. UCLA determined that the primary target population of Monterey was homeless.

Pilot Reporting of Target Populations by Enrollee

Monterey County WPC pilot reported on five of the six DHCS-defined target populations: high utilizers, chronic physical conditions, SMI/SUD, homeless and justice-involved (Exhibit 11). Although they reported on many of the target populations, the main target population of the program was homeless individuals. The other criteria were not a requirement to participate and were used mainly to prioritize those that were enrolled in the program.

Exhibit 11: Monterey WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X		X
Pilot's Primary Target Populations				X		

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Napa's Target Populations

Description from Application

In their application, Napa County Health and Human Services Agency (HHSA) indicated that their target population would be individuals experiencing homelessness or at-risk of homelessness. They would prioritize these individuals for enrollment if they were high system users and have a physical disability, serious mental illness or substance use disorder, or co-occurring disorders.

Changes during WPC and Primary Target Population Determination

Through structured interviews with UCLA, Napa County HHSA indicated that they have mainly focused on chronically homeless individuals during the first phase of their Pilot. They used the HUD definition of homelessness and found that most of their chronically homeless enrollees have a SMI, SUD or other physical disability. However, they were no longer focusing on the criteria they outlined in their application for prioritizing enrollees. In addition, due to unexpected difficulties in gaining access to partner data, it was difficult to determine whether or not potential enrollees had the priority criteria prior to completion of a release of information consent form during the enrollment process. Ultimately, UCLA determined that their primary target populations were homeless or at-risk-of-homelessness.

Pilot Reporting of Target Populations by Enrollee

In their enrollment and utilization reports, Napa County HHSA only reported on one target population, homeless (Exhibit 12). Although they aimed to target homeless and individuals that are at-risk of homelessness, they started the program by only enrolling those that have been chronically homeless.

Exhibit 12: Napa WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting				X		
Pilot's Primary Target Populations				X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Orange's Target Populations

Description from Application

In their application, County of Orange Health Care Agency (HCA) indicated that they would target two populations: 1) homeless and 2) SMI and SMI homeless. The first target population was individuals experiencing homelessness. To ensure that this target population would benefit from WPC services, they focused on those individuals that had visited the ER for care, particularly those that accessed the ED two or more times in a rolling three-month period. The second target population included individuals with serious mental illness (SMI) and SMI homeless. Given that these individuals were served through the County's Behavioral Health Services and regulations prevented sharing of data from Behavioral Health, these individuals could not be properly identified through the initial homeless search.

Changes during WPC and Primary Target Population Determination

Through structured interviews, UCLA determined that the target population of Orange HCA's WPC pilot had evolved slightly from what was originally proposed in their application. Specifically, the target population of the Pilot was defined as homeless individuals. Individuals experiencing homelessness with SMI was a subpopulation of their target population. In general, individuals were engaged and enrolled into the Pilot through contacts with participating emergency departments, clinics and shelters and through outreach programs known to individuals experiencing homelessness. The additional criteria listed in the application was thus not required, but would likely be met given the method of engagement. UCLA determined that their primary target population were homeless and SMI/SUD.

Pilot Reporting of Target Populations by Enrollee

In their enrollment and utilization reports, Orange HCA reported on three target populations: SMI/SUD, homeless and at-risk of homelessness (Exhibit 13). The at-risk-of-homelessness target population was only used when an enrolled individual had initially secured housing. Once in the at-risk-of-homelessness target population, individuals were disenrolled from the pilot if they remained housed for six months.

Exhibit 13: Orange WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting			X	X	X	
Pilot's Primary Target Populations			X	X		

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Placer's Target Populations

Description from Application

In their WPC application, Placer County Health and Human Services (HHS) indicated that they would focus on several target populations for their pilot to ensure serving enough individuals even though Placer is not a small county. They aimed to serve 450 adult individuals throughout the duration of the program who fit the following target populations:

1. History of repeated incidents of avoidable ED use and hospital readmissions (top 5% of their service population in terms of cost of services)
2. Two or more chronic health conditions (including heart disease, diabetes, COPD, unmanaged cholesterol, obesity, and high blood pressure)
3. Severe mental health diagnoses and/or substance use disorder
4. Currently homeless or at-risk of homelessness
5. Scheduled for release from jail and meet at least one WPC target population criteria

Additionally, individuals needed to be eligible for Medi-Cal.

Changes during WPC and Primary Target Population Determination

Through structured interviews with UCLA, they indicated that they had purposefully kept their target population as broad as possible in order to allow for flexibility in their program. Not only would they be able to serve more individuals, but they would also be able to test strategies to help a variety of populations. Ultimately, UCLA determined that Placer's primary target populations included all six DHCS-defined groups.

Pilot Reporting of Target Populations by Enrollee

At the individual-level, Placer reported enrollees in all six target populations (Exhibit 14).

Exhibit 14: Placer WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations	X	X	X	X	X	X

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Riverside's Target Populations

Description from Application

In their application, Riverside University Health System (RUHS) was targeting probationers with the following criteria:

- New probationers
- On probation for at least one full year
- At-risk of or experiencing homelessness
- Have a behavioral health diagnosis
- Have a physical health diagnosis

Potential enrollees would be screened and enrolled at their first probation visit.

Changes during WPC and Primary Target Population Determination

During UCLA structured interviews, RUHS leadership indicated that their target population remains probationers. UCLA determined their primary target population was justice-involved.

Pilot Reporting of Target Populations by Enrollee

Initially, RUHS believed that enrollees needed to meet all six target populations designated by DHCS for WPC. However, after the first year of enrollment, DHCS clarified that only screening and Medi-Cal eligibility was required. As a result, all enrollees are in the six target populations in the first year, but are no longer in all the target populations starting in the second year (Exhibit 15).

Exhibit 15: Riverside WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations						X

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Sacramento's Target Populations

Description from Application

In their application, the city of Sacramento indicated that their Pilot would target individuals with repeated incidents of avoidable ED use and/or hospital admissions, defined as two or more ED visits or inpatient hospitalizations or one ED visit and two or more comorbid conditions, and those who are homeless or at-risk-of-homelessness. Additionally, potential enrollees would need to be Medi-Cal enrolled or eligible and reside in Sacramento County.

Changes during WPC and Primary Target Population Determination

Through structured interviews, UCLA determined that the target population of Sacramento's WPC Pilot remained high utilizers that are homeless. The data used to determine an enrollee's eligibility has evolved over implementation. Sacramento initially tried to get a list of potential enrollees from the health plan but found it was too difficult to outreach and engage through this method. They then transitioned to a hot-spotting method, which sought out locations where their target populations tended to be and developed a referral system at the ERs and hospitals. Ultimately, the pilot's primary target populations were homeless and high utilizers.

Pilot Reporting of Target Populations by Enrollee

In their enrollment and utilization reports, Sacramento initially reported on all target populations apart from justice-involved (Exhibit 16). Through clarification on reporting requirements with DHCS, they stopped reporting on all the target populations that were not in their target population criteria (chronic physical conditions and SMI/SUD). Sacramento had strict eligibility criteria and therefore, individuals that were not reported as high utilizers and homeless or at-risk of homelessness were likely misreported.

Exhibit 16: Sacramento WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	
Pilot's Primary Target Populations	X			X		

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

San Benito's Target Populations

Description from Application

In their application, San Benito County Health and Human Services Agency indicated that their target population would be individuals who are homeless or at-risk of homelessness and have one or more of the following:

- Behavioral health condition (mental illness, substance abuse or co-occurring diagnosis)
- Repeated incidents of ED use, hospital admissions or nursing facility placement
- Two or more chronic conditions
- Recently released from institutions or connections to the criminal justice system.

Additionally, enrollees needed to be between 18 and 64 years old and eligible for Medi-Cal.

Changes during WPC and Primary Target Population Determination

During UCLA structured interviews, San Benito indicated that through implementation the focus of the program had shifted to high-utilizing individuals that are homeless or at-risk of homelessness. This shift was mainly brought on by their first enrollees, whom typically were homeless or at-risk of homelessness and had a connection to the criminal justice system. Without evidence of high utilizations in the past, the goals of the Pilot to reduce the use of avoidable ED use and inpatient hospitalization were not going to be realized and these individuals were not benefiting from the services provided. Additionally, these first enrollees were often disenrolled quickly due to lack of engagement. UCLA determined the primary target populations to be high utilizers, homeless and at-risk-of-homelessness.

Pilot Reporting of Target Populations by Enrollee

While San Benito reports on all six of the DHCS-designated target populations, the focus of their program was high utilizers, homeless and at-risk-of-homelessness (Exhibit 17). In order to determine a potential enrollee's utilization and homelessness status they used data from the hospital in addition to self-report and observation.

Exhibit 17: San Benito WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations	X			X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

San Bernardino's Target Populations

Description from Application

In their application, San Bernardino County's Designated Public Hospital, Arrowhead Regional Medical Center (ARMC) indicated they aim to target the most vulnerable population at-risk for frequent, emergency medical and behavioral services. In order to determine the population, they collected data from ARMC, Public Health, and Behavioral Health and scored individuals based on emergency visits, inpatient hospital stays and urgent care visits. ARMC planned to update the list yearly and methodology for scoring as necessary. Initially, the scoring has been based on the following rubric:

Exhibit 18: San Bernardino Target Population Scoring Rubric

Procedure	Point Value Given
Hospital medical inpatient	1 point per day
ED encounter	3 points per encounter/admission/event
Psychiatric/SUD inpatient admission	3 points per admission
Psychiatric/SUD acute care	1 point per day
Urgent/express/crisis care	1 point per event
Public health utilization	0.5 point per encounter
Flagged as Chronically Homeless (overrides either below)	300 points
Most recent prior residence homeless	200 points
Most recent prior residence temporary (receiving services, so at risk of homelessness)	150 points
Most recent prior residence permanent (receiving services, so at risk of homelessness)	100 points

This rubric was supposed to prioritize individuals that are both high utilizers and homeless or at-risk of homelessness. In addition, enrollees needed to be Medi-Cal eligible.

Changes during WPC and Primary Target Population Determination

ARMC continued to use a list of potential enrollees created using a scoring algorithm. However, there have been updates to the scoring algorithm. For example, the algorithm initially counting each inpatient day has been changed to counting each admission. Additionally, there were no longer elements about homelessness in the algorithm and instead chronic physical conditions have been included. ARMC used this system so that everyone in the county had the opportunity to be part of the Pilot. They were concerned that if they used referrals, there would be bias towards certain providers. The focus of the program was to address individuals with high utilization. Chronic physical conditions helped prioritize those individuals with potential for

intervention. Ultimately, UCLA determined that high utilizers was the primary target population.

Pilot Reporting of Target Populations by Enrollee

In enrollment and utilization data, ARMC reported on two target populations that aligned with their target population scoring algorithm: high utilizers and chronic physical conditions (Exhibit 19).

Exhibit 19: San Bernardino WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X				
Pilot's Primary Target Populations	X					

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

San Diego's Target Populations

Description from Application

In their application, the County of San Diego Health and Human Services Agency indicated that their target population would be high-cost, frequent users of ED and/or inpatient services identified by the Medi-Cal managed care plans who:

- Are currently experiencing homelessness or are at-risk of homelessness and
- Have a mental health condition, substance use disorder, or chronic physical health condition/s

In addition, enrollees needed to be Medi-Cal eligible. San Diego defined high users as individuals having more than $40,000 in Medi-Cal paid claims and at least five ED visits or three inpatient hospitalizations. They aimed to exclude individuals with terminal illnesses.

Changes during WPC and Primary Target Population Determination

Due to the normal lag in Medi-Cal claims, which resulted in a delay identifying high-utilizers with health conditions or behavioral disorders, San Diego has focused less on lists of eligible enrollees from their managed care plans and relied more on community referrals. San Diego still defined their target population as individuals that are homeless or at-risk of homelessness and high utilizers. However, they have made a few exceptions to the high utilizer criteria if it was apparent that the individual had high need and was likely to end up a high utilizer without intervention. San Diego intended for the additional criteria included in the target population definition to assist in prioritizing enrollees and describe the enrolled population. UCLA determined the primary target populations to be high utilizers, homeless and at-risk-of-homelessness.

Pilot Reporting of Target Populations by Enrollee

San Diego reported on all six target populations designated by DHCS (Exhibit 20). For first two quarters of 2018, they were building their relationship with the justice system and therefore were not able to systematically capture information on this target population. Additionally, as they developed the system used to capture all the information needed to determine an enrollee's target populations, there was a potential lag in the time to collect the necessary information. As a result, the most complete target population information might not have been available in the first months of enrollment.

Exhibit 20: San Diego WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations	X			X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

San Francisco's Target Populations

Description from Application

In their application, the San Francisco Department of Public Health (SFDPH) indicated that their target population was Medi-Cal enrolled homeless adults. In order to prioritize individuals for WPC services, SFDPH developed a risk-based stratification of the homeless population. Severe risk has been defined as the top 5% of urgent/emergency services and individuals homeless for more than 10 years (in SFDPH's Coordinated Care Management System (CCMS)). High risk was defined as the top 5% of urgent/emergency services and individuals homeless for less than 10 years (in CCMS). Elevated risk included individuals who were not part of the top 5% of urgent/emergency services and were homeless for less than 10 years (in CCMS).

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, San Francisco indicated the target population remained individuals experiencing homelessness identified through CCMS. They continued to use historical data to stratify their target population into severe risk, high risk and elevated risk. UCLA determined the primary target population was homeless.

Pilot Reporting of Target Populations by Enrollee

In San Francisco's enrollment and utilization reports, they reported WPC enrollees in two possible target populations: high utilizers and homeless (Exhibit 21). All enrollees were included in the homeless target population.

Exhibit 21: San Francisco WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X			X		
Pilot's Primary Target Populations				X		

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

San Joaquin's Target Populations

Description from Application

In their application, the San Joaquin County Health Care Services Agency indicated that they would target three populations:

1. Adult Health Plan of San Joaquin (HPSHJ) that are assigned to the FQHC look-alike clinics and are over utilizers of the emergency department
2. Adults with a mental health and/or substance use disorder
3. Adults experiencing homelessness or at-risk of homelessness upon discharge from the hospital, medical center, psychiatric health facility, or county jail

In addition, the enrollee needed to be a Medi-Cal beneficiary.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, San Joaquin indicated that all enrollees had to fit into at least one target population, but often they fit into more than one. An enrollee might be referred for homelessness, but then later identified as a high utilizer as well. Data came from referral forms, EHS, HMIS, HIE, jails, among many other sources. UCLA determined that high utilizers, SMI/SUD, homeless and at-risk-of-homelessness were the primary target populations.

Pilot Reporting of Target Populations by Enrollee

San Joaquin reported individuals in all DHCS-defined target populations except chronic physical conditions (Exhibit 22). San Joaquin did not use SMI/SUD in 2017 because partners were not providing the data as they were finalizing data sharing agreements. Many enrollees had mild to moderate mental illness rather than severe mental illness so were not identified as having mental illness. They added justice-involved later in 2018.

Exhibit 22: San Joaquin WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X		X	X	X	X
Pilot's Primary Target Populations	X		X	X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

San Mateo's Target Populations

Description from Application

In their application, San Mateo County Health System identified three target populations for their Pilot. These target populations included:

- High utilizers with mental illness and/or medical conditions who present frequently to EDs, Psychiatric Emergency Services (PES), and/or have avoidable or extended stays in residential treatment
- High utilizers with untreated SUD
- High utilizers with similar clinical profiles previously listed, but are also identified homeless or recently released from jail

Changes during WPC and Primary Target Population Determination

San Mateo has found in practice that these categories were often fluid. As initially designed, the target population was supposed to map to specific teams, but this has not been the case. As a result, the PMPM bundle did not accurately tell which services the client was receiving. If enrollees got a Behavior Health and Recovery Services (BHRS) "touch", they were in that bundle, but Bridges to Wellness served people in all three target populations and across all PMPMs. The initial list of enrollees was identified through referrals and lists of individuals with more than four ED visits. Ultimately, UCLA determined that high utilizers was the primary target population.

Pilot Reporting of Target Populations by Enrollee

All enrollees were in the high utilizer target population (Exhibit 23). San Mateo determined if an enrollee was also included in the SMI/SUD target population depending on the services the enrollee received. Enrollees were included in the homeless target population based on registration information from their electronic health record. This information was not always up to date and it is likely that the number of enrollees experiencing homelessness has been under reported.

Exhibit 23: San Mateo WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X		X	X		
Pilot's Primary Target Populations	X					

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Santa Clara's Target Populations

Description from Application

In their application, Santa Clara Valley Health and Hospital System (SCVHHS) indicated that their target population was high utilizers of multiple systems (HUMS) who are Medi-Cal enrolled, engaged in two or more systems of care and in the top 5% of utilizers for SCVHHS encounters over the past year. While they acknowledged that many individuals within this population have co-occurring physical and behavioral health issues, experience homeless and/or be justice-involved, they believed the program could make the most impact with the top 5% HUMS.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Santa Clara indicated that the Center for Population Health Improvement (CPHI) aggregated data from SCVHHS departments (e.g., Santa Clara Valley Medical Center, Office of Supportive Housing, Custody, Behavioral Health) and Valley Health Plan claims. Based on these data sources they developed a statistical point system which assigned different values depending on the patient's type of clinical encounters in the past year (e.g., emergency and psychiatric encounters receive more points than an ambulatory care visit; inpatient stays are capped at 75th percentile). Santa Clara targeted the top 10% high-scoring individuals for enrollment in the program (~10,000 potential clients). Ultimately, this system aimed to identify high utilizers, which UCLA determined as the primary target population.

Pilot Reporting of Target Populations by Enrollee

In Santa Clara's enrollment and utilization reports, they identified individuals in four target populations (Exhibit 24).

Exhibit 24: Santa Clara WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X		
Pilot's Primary Target Populations	X					

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Santa Cruz' Target Populations

Description from Application

In their application, the County of Santa Cruz Health Services Agency (HAS) identified the WPC Pilot target population as adult Medi-Cal beneficiaries with at least one of the following characteristics:

- Repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement
- Two or more chronic conditions
- Mental health and/or substance use disorders
- Currently experiencing homelessness
- At-risk of homelessness and require intensive housing support to live in the community due to their mental illness, substance use disorder and co-occurring health condition
- Post incarceration; could include probation or parole status.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Santa Cruz indicated that they focused on those with co-occurring behavioral health (including SUD) and physical chronic conditions. In particular, they focus on high-cost chronic conditions, but they also took into account high-utilization or medication history when determining if an individual met their criteria. UCLA determined the primary target populations were chronic physical conditions and SMI/SUD.

Pilot Reporting of Target Populations by Enrollee

While the WPC Pilot reports on all six target populations, the main focus of their pilot was individuals with co-occurring behavioral health and chronic physical conditions (Exhibit 25). This has been reflected by the fact that almost all enrollees were in the SMI/SUD target population, except for individuals with mild or moderate mental illness.

Exhibit 25: Santa Cruz WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	X
Pilot's Primary Target Populations		X	X			

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Shasta's Target Populations

Description from Application

In their application, the Shasta County Health and Human Services Agency (HHSA) indicated that their target population was adults ages 18 to 64 with two or more ED visits or hospitalizations in the last three months and are homeless or at-risk of homelessness. Potential enrollees also needed to fulfil one or more of the following criteria:

- SMI diagnosis
- SUD diagnosis
- Undiagnosed/undisclosed opioid addiction

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Shasta County HHSA indicated that their target population was high utilizers with an emphasis on individuals with chronic illness, SUD and homelessness. UCLA determined that their primary target population was high utilizers, chronic physical conditions, SMI/SUD, homeless and at-risk-of-homelessness.

Pilot Reporting of Target Populations by Enrollee

While Shasta reported on all target populations except for justice-involved, the pilot aimed to provide services for individuals that met the high utilizer criteria (Exhibit 26).

Exhibit 26: Shasta WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	
Pilot's Primary Target Populations	X	X	X	X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Solano's Target Populations

Description from Application

In their application, Solano identified their target populations as individuals with the highest medical utilization, repeated incidents of avoidable ED use, and two or more chronic and serious health conditions, with at least one being mental health and/or substance use disorders. Enrollees were identified using data from Partnership Health Plan.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Solano indicated that outreach and enrollment was originally intended to be based on a list compiled by the managed care organization which would identify high utilizers with chronic conditions. However, they found that individuals on the list were not always appropriate for the program and some individuals were not willing to participate in the program. Therefore, they expanded their approach to include referrals from community based organizations (CBOs), emergency departments and clinics. Individuals referred into the program still needed to meet the Pilot eligibility criteria (e.g., high utilizer with two or more chronic conditions, one of which must be SMI and/or SUD). Solano expanded its definition of high utilizers but individuals still needed to have repeated, avoidable ED use. The majority of enrollees were homeless or at-risk of homelessness. Ultimately, UCLA determined that high utilizers and SMI/SUD were the primary target populations.

Pilot Reporting of Target Populations by Enrollee

While Solano reported on four of the six DHCS-designated target populations (high utilizers, SMI/SUD, homeless and at-risk of homelessness), the pilot target population of the pilot included only the high utilizer and SMI/SUD populations (Exhibit 27). Solano captured the additional target populations due to the information already being collected for reporting purposes.

Exhibit 27: Solano WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X		X	X	X	
Pilot's Primary Target Populations	X		X			

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Sonoma's Target Populations

Description from Application

In their application, the County of Sonoma Department of Health Services Behavioral Health Division indicated that their target population has been individuals who are homeless or at-risk-of-homelessness who also have a serious mental illness and at least one of the following:

- Co-occurring health conditions including substance use disorders
- High users of emergency services
- Served by multiple agencies

In addition, the enrollee needed to be eligible for Medi-Cal. They also indicated that they would focus on elderly individuals who are difficult to place since they often experience the longest waits for appropriate placement.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Sonoma County indicated that their target population had changed from their initial application. In particular, individuals did not need to have a severe, persistent mental illness and Sonoma also worked with individuals with high/moderate mental health conditions. Additionally, included individuals could be high utilizers of mental health or medical emergency room services. UCLA determined the primary target populations as SMI/SUD, homeless and at-risk-of-homelessness.

Pilot Reporting of Target Populations by Enrollee

While Sonoma County did report on all but one of the target populations designated by DHCS (no justice-involved reported), the specifically targeted populations of the Pilot were the SMI/SUD, homeless and at-risk of homelessness populations (Exhibit 28).

Exhibit 28: Sonoma WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X	X	X	X	X	
Pilot's Primary Target Populations			X	X	X	

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Ventura's Target Populations

Description from Application

In their application, Ventura County Health Care Agency identified their target population as adult (ages 18 or older) high utilizers with at least four ED visits and/or two inpatient visits. Furthermore, the Pilot prioritized individuals who are homeless or at-risk of homelessness and/or with SUD or mental illness. All enrollees needed to be Medi-Cal eligible.

Changes during WPC and Primary Target Population Determination

Through UCLA conducted interviews, Ventura indicated that they went with a general target population in order to have the most flexibility. As a result, Ventura would be able to serve any high-need population including individuals with multiple chronic conditions, SMI/SUD, or currently experiencing homelessness. High utilizer was their primary target population.

Pilot Reporting of Target Populations by Enrollee

Given that the pilot aimed to provide services for individuals that met their high utilizer criteria, the only target population that Ventura reported was high utilizer (Exhibit 29). In addition, the pilot used a four-point question to determine if an enrollee is homeless and indicated that status under the homeless variable.

Exhibit 29: Ventura WPC Pilot Target Populations

	High Utilizers	Chronic Physical Conditions	SMI/SUD	Homeless	At-risk of Homelessness	Justice-Involved
Individual-level Target Populations Reporting	X					
Pilot's Primary Target Populations	X					

Source: Whole Person Care Pilot Applications (n=25), 2016, Follow-up Interviews with Lead Entities and Frontline Staff (n=27), September 2018-March 2019, and WPC Enrollment and Utilization Reports from PY 2 to PY 3.

Appendix K: Detailed Difference-in-Difference Results

Exhibit 1: Difference-in-Difference Analyses of Universal Metrics between WPC Medi-Cal Samples

Metric	Person-Years	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	Change from Pre to Post	Difference in Differences
2.1 - Ambulatory Care (AMB) - Emergency Department (ED) Visits							
WPC Enrollees	329,332	143.48	167.88	172.72	139.89	0.62	0.12
Control Group	644,836	134.81	158.67	153.32	141.17	0.51	
2.2 - Inpatient Utilization (IPU)							
WPC Enrollees	329,332	86.56	103.89	115.08	110.31	17.47*	10.06*
Control Group	644,836	60.48	73.75	89.39	59.66	7.41*	
2.3 - Follow-Up after Hospitalization for Mental Illness (FUH) - Within 30 Days of Discharge							
WPC Enrollees	22,189	75.25%	76.91%	82.05%	84.40%	7.14%*	2.78%*
Control Group	27,958	78.05%	79.44%	80.72%	85.50%	4.36%*	
2.3 - Follow-Up after Hospitalization for Mental Illness (FUH) - Within 7 Days of Discharge							
WPC Enrollees	22,189	57.96%	57.33%	61.76%	60.42%	3.44%*	2.94%*
Control Group	27,958	61.28%	60.27%	59.66%	62.90%	0.51%	
2.4 - Initiation of Alcohol and Other Drug Dependence WPC Enrollees (IET-14)							
WPC Enrollees	77,782	39.67%	41.81%	47.85%	46.38%	6.38%*	4.01%*
Control Group	114,211	40.46%	42.90%	43.47%	44.61%	2.36%*	
2.4 - Engagement of Alcohol and Other Drug Dependence WPC Enrollees (IET-30)							
WPC Enrollees	35,510	42.32%	42.52%	48.57%	48.71%	6.22%*	4.56%*
Control Group	51,238	45.64%	45.68%	47.13%	47.53%	1.66%*	
Ever Had an ED Visit							
WPC Enrollees	329,332	49.33%	57.07%	46.28%	34.22%	-12.95%*	-0.92%*
Control Group	644,836	49.96%	57.20%	46.68%	36.41%	-12.04%*	
Ever Had an IP Admission							
WPC Enrollees	329,332	21.10%	25.32%	20.66%	13.76%	-6.00%*	-1.48%*
Control Group	644,836	19.19%	23.10%	18.59%	14.65%	-4.52%*	

Exhibit 2: Difference-in-Difference Analyses of Variant Metrics between WPC Medi-Cal Samples

Metric	Person-Years	Pre-WPC Year 1	Pre-WPC Year 2	WPC Year 1	WPC Year 2	Change from Pre to Post	Difference in Differences
3.1.1 - All-Cause Readmissions (ACR) - All Pilots							
WPC Enrollees	43,191	15.74%	15.78%	18.33%	15.47%	1.14%*	1.44%*
Control Group	66,319	9.59%	9.94%	9.54%	9.39%	-0.30%	
3.1.1 - All-Cause Readmissions (ACR) - Participating Pilots							
WPC Enrollees	26,041	18.62%	19.34%	21.34%	16.97%	0.17%	0.53%
Control Group	35,793	10.47%	11.08%	10.55%	10.28%	-0.36%	

Appendix L: Care Coordination Policy Brief

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UCLA CENTER FOR HEALTH POLICY RESEARCH

Health Policy Brief

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Whole Person Care Improves Care Coordination for Many Californians

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"Delivery of integrated services may improve the patient experience and reduce health care use and costs."

SUMMARY: California's Whole Person Care (WPC) Pilots implemented under the Section 1115 Medicaid Waiver, "Medi-Cal 2020," are designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. We examined literature on care coordination and developed a framework for assessing the progress of WPC Pilot implementation in eight key areas. Three years into the program, results show that WPC Pilots successfully implemented many essential care coordination processes, but they continued to further develop needed infrastructure. These findings highlight opportunities and challenges in implementing a cross-sector care coordination program for patients with complex health and social needs.

The U.S. health care delivery system has long been fraught with inefficiencies rooted in part in fragmentation of care and professional silos. Frequently, patients with chronic and complex needs must navigate between medical, behavioral health, and social service providers who are not prepared or equipped to provide them with holistic care. Preliminary evidence suggests that delivery of integrated services may improve the patient experience and reduce health care use and costs.[1-3]

In 2016, California began implementing the WPC Pilot demonstration project to promote systematic delivery of coordinated care and evaluate its impact on health care costs and use for Medicaid (called Medi-Cal in California) beneficiaries.[4,5] The WPC Pilot is part of California's Section 1115 Medicaid waiver, known as "Medi-Cal 2020." The aim of WPC is to improve coordination of medical, behavioral health, and social services for patients who use a high level of Medi-Cal services and ultimately improve patient health and reduce Medi-Cal expenditures.

A total of 25 pilot programs in 26 selected counties[a] (hereafter referred to as WPC Pilots) were established by 2017. All WPC Pilots were led by a single, designated lead entity (LE), typically a county Health and Human Services Agency. These LEs partnered with health plans and other service providers to coordinate medical, behavioral health, and social services for targeted Medi-Cal beneficiaries. Specifically, WPC Pilots were expected to systematically identify target populations, share data, coordinate care, and evaluate improvements in the health of enrolled populations.

a Twenty-seven counties initially implemented WPC Pilots, but Plumas County (part of the Small County WPC Collaborative with Mariposa and San Benito Counties) dropped out in September 2018.

"Effective cross-sector care coordination requires timely sharing of information among the care coordination team and providers."

Acknowledging heterogeneity in how publicly funded services are structured and delivered across California, WPC Pilots had considerable flexibility in the selection of target populations, outreach methods, services provided, and outcomes tracked. WPC Pilots also differed significantly in the amount of WPC funds requested and allocated to develop infrastructure for care coordination.[6] Information on specific characteristics of each WPC Pilot is provided in Appendix 1: *https://healthpolicy.ucla.edu/publications/Documents/PDF/2019/wpc-appendix-datatable.pdf*.

What is Care Coordination?

The Agency for Healthcare Research & Quality (AHRQ) defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."[7] Care coordination is distinct from care management, which is more focused on management of chronic medical and psychosocial conditions, and from case management, which includes services that help patients develop skills to access services and meet their basic needs.[9] We drew on elements of care coordination identified by AHRQ and an extensive review of the literature to develop a framework of elements critical for cross-sector care coordination. We then used this framework to assess care coordination under WPC.

Cross-Sector Care Coordination Framework

Cross-sector care coordination requires availability of infrastructure to support delivery of effective care coordination processes (Exhibit 1).

Care coordination infrastructure elements include (1) care coordination staffing that meets patient needs, (2) data sharing capabilities to support care coordination, (3) standardized organizational protocols to support care coordination, and (4) financial incentives to promote cross-sector care coordination.

Care coordination staffing that meets patient needs. To successfully coordinate care across sectors, staff must have sufficient capacity to effectively engage with patients to address a wide range of medical, behavioral, and social needs. Staffing levels appropriate for meeting patient needs include (1) developing a multidisciplinary team with relevant and diverse clinical expertise, (2) inclusion of peers with lived experience to build trust and promote compliance of complex patients, and (3) staff workload that ensures sufficient availability to meet patient needs.[10-12]

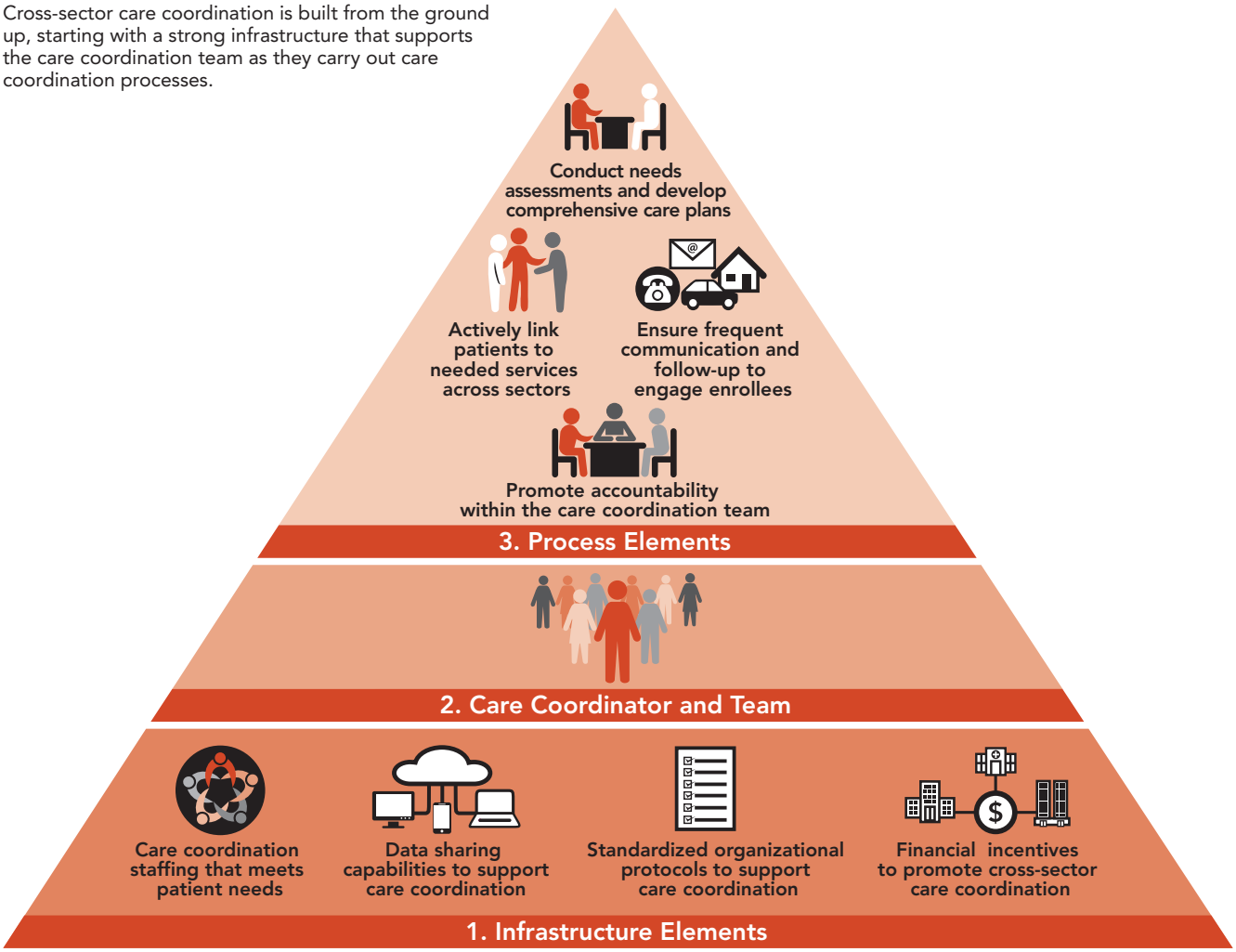
Data sharing capabilities to support care coordination. Effective cross-sector care coordination requires timely sharing of information among the care coordination team and providers. Data sharing infrastructure that facilitates this type of information exchange includes (1) formal agreements that define terms and conditions of data sharing with key partners; (2) a universal consent form to reduce barriers to sharing patient data; (3) use of an electronic data sharing platform that includes key information such as comprehensive care plans; (4) medical, behavioral health, and social service use data; and (5) capacity to track and report care coordination activities. Ideally, care coordinators can also access this data sharing system to (6) view and enter data (7) remotely (i.e., in the field) and (8) in real-time.[13-15]

Standardized organizational protocols to support care coordination. Standardized protocols help minimize undesirable variation in delivery of care coordination services.[16] These include protocols for (1) referring patients to needed medical, behavioral, and social services; and (2) monitoring receipt of services and tracking patient outcomes.

Financial incentives to promote cross-sector care coordination. Financial incentives can facilitate organizational buy-in and accountability for cross-sector care coordination.[3,17] Financial incentives that help align organizational priorities with these care coordination goals

Conceptual Framework of Cross-Sector Care Coordination **Exhibit 1**

Cross-sector care coordination is built from the ground up, starting with a strong infrastructure that supports the care coordination team as they carry out care coordination processes.



include use of payment mechanisms that (1) are risk-stratified and address financial risk assumed by providers and (2) reward better performance via incentive payments.

Care coordination process elements include (1) ensuring frequent communication and follow-up to engage enrollees, (2) conducting needs assessments and developing comprehensive care plans, (3) linking patients to needed services and follow-up to ensure receipt of services, and (4) following protocols to promote accountability among care coordination teams.

Ensure frequent communication and follow-up to engage patients. Effectively engaging complex patients in care coordination requires the adoption of patient-centered communication strategies. These include outreach or other contact with patients (1) in-person, at least initially, to build trust and engagement; (2) wherever and whenever they can be found, including in the field; and (3) frequent follow-up, i.e., more than once per month.[18]

Conduct needs assessments and develop comprehensive care plans. Full assessment of patient medical, behavioral, and social needs is essential to developing a comprehensive care plan. These care plans identify patient goals, the actions needed to achieve these goals, and resources or supports needed to ensure successful delivery of care.[14,15,19] Patients should have a single care plan shared across all providers that is updated regularly

Exhibit 2 Care Coordination Infrastructure in WPC Pilots

Care coordination framework element	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa	Mendocino	Monterey	Napa	Orange	Placer	Riverside	Sacramento	San Benito	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura	Total Pilots
Care coordination infrastructure																											
Care coordination staffing that meets patient needs																											
Multidisciplinary care coordination team composition*	CHW, N, SW, MD, H	CHW, N, SW, C, MH, BS, H	MA, MD, SW	CHW, BS, H, MH, C	CHW, SW	MA, N, SW, MH, H	MH, N, MD, H, SW	N, MH, BS, H, C, CHW	N, MH, SW, C, H, BS	SW, CHW, MH, N, H	MH, N, SW. CHW	CHW, N	N, MH, C, H, BS, CHW	CHW, N, SW, H	SW	CHW, C, N, SW	SW, CHW, MD, H, N	CHW, N, MH, MD, SW	MH, CHW, N	CHW, SW, N, MD, C	CHW, SW, N, MD, MH	SW	N, SW, BS, H	SW, CHW, H, MH, C, BS	C, BS, MH, SW, H, CHW, N	N, MH, CHW, MA, C, BS, H, MD	1
Use of workers with lived experience	•	•		•	•	•		•		•	•	•	•	•		•	•	•		•	•	•		•	•	•	20
Workload**	20-30	90-350	125-150	10-20	15-40	17-30	20-25	15-20	40	40	10-60	15	70-100	25-75	8-10	50	10-25	20-30	15-150	12-30	10- 50	25	20-25	20	15	60	Median = 20-30
Data sharing capabilities to support care coordination																											
Data sharing agreements among key partners	Some	All	Some	All	All	All	All	Some	All	Some	All	Some	All	Some	Some	All	All	Some	Some	Some	All	All	All	All	All	Some	All=15, Some=11, None=0
Universal consent form		•	•	•	•	•	•	•		•	•		•	•	•		•		•		•		•	•		•	18
Electronic capture of comprehensive care plan		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•			•	•	•	22
Frontline staff track and report on care coordination activities in a single electronic system		•		•		•	•		•		•				•	•	•							•			10
Read and write access to shared data for frontline staff	•	•	•	•	•	•	•		•		•	•	•	•	•	•	•	•	•		•	•		•		•	21
Real-time access to shared data for frontline staff	•	•									•	•		•			•			•	•					•	9
Remote access to shared data for frontline staff	•	•		•	•	•	•		•		•	•	•	•	•		•					•		•	•	•	17
Access to medical, behavioral health and social service data		•		•	•		•		•		•	•	•	•	•	•	•			•	•	•			•	•	17

Data Source: WPC applications, mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services, interviews conducted with representatives of each Pilot from September 2018 to March 2019, and surveys of WPC organizations administered in the summer and fall of 2018.

* Types of staff directly involved in care coordination: CHW=Community Health Worker or Peer Support, MA=Medical Assistant, N=Nurse or Licensed Vocational Nurse, SW= Social Worker, C= Alcohol and Drug Counselor, MD=Physician or Nurse Practitioner, MH=Mental Health Professional/Counselor, BS=Benefit Support (includes job support), H=Housing Support.

** Workload refers to the average number of enrollees per care coordinator. Wide workload ranges were typically associated with WPC Pilots' use of risk-stratified PMPM bundles, in which intensity of services was tailored based on enrollee risk. In these situations, care coordinators working with higher acuity enrollees often had significantly lower caseloads than those working with lower acuity enrollees.

Care Coordination Infrastructure in WPC Pilots (continued) **Exhibit 2**

Care coordination framework element	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa	Mendocino	Monterey	Napa	Orange	Placer	Riverside	Sacramento	San Benito	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura	Total Pilots
Care coordination infrastructure																											
Standardized organizational protocols to support care coordination																											
Standardized referral protocols	•	•	•	•	•		•		•	•	•	•	•		•						•			•	•	•	16
Standardized protocols for monitoring and follow-up		•	•	•	•	•			•	•	•		•		•	•	•	•			•			•	•	•	17
Financial incentives to promote cross-sector care coordination																											
Risk-stratified PMPM bundles†	•	•		•	•			•			•			•				•			•					•	10
Contracted care coordination services (All)	All	None	None	All	Some	All	None	All	Some	All	All	None	None	All	None	None	All	Some	All	Some	Some	Some	Some	Some	All	Some	Some	All=10, Some=9, None=7
Financial incentives for contractors††	•	–	–			•	–	•	•	•		–	–	•	–	–	•		•	•	•	•	•			•	•	14

† Pilots were identified as having risk-stratified PMPM bundles when enrollees were stratified into different PMPM bundles at intake based on an assessment of risk.

†† Financial incentives for contactors were assessed only when care coordination services were contracted out rather than provided directly by the lead entity.

to address changes in patient needs over time, i.e., more frequently than once per year.

Actively link patients to needed services across sectors. Active referral strategies, e.g., through directly arranging services on the patient's behalf, are more effective in service uptake than informational referral strategies, such as giving patients information about available treatment options and leaving them to navigate the rest.[16] Successful care coordination includes active referral to needed medical and behavioral health, including mental health or substance abuse treatment, and social services such as housing or benefits assistance.

Promote accountability within the care coordination team. Care coordination is most effective when accountability for different activities is clearly defined and monitored. Strategies that support accountability for care coordination could include regular meetings and case conferences with care coordinators or care teams to share expertise, negotiate differences in judgment, and define priorities for patient care.[20]

"Care coordination is most effective when accountability for different activities is clearly defined and monitored."

Evaluation of Care Coordination under WPC

Data for the evaluation of care coordination under WPC was gathered between September 2018 to March 2019 using WPC applications, a structured survey, and follow up interviews with leaders, care coordinators, and other WPC Pilot staff.[b] Additional details about care coordination efforts of individual WPC Pilots can be found here: *https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1844*.

Infrastructure

WPC Pilots reported significant progress in establishing the infrastructure needed to coordinate the care of enrollees in the first 3 years of implementation (Exhibit 2).

b See Data and Methodology section.

"Over half of WPC Pilots reported successfully sharing comprehensive medical, behavioral health, and social services data with partners."

Pilots differed, however, in infrastructure investments, data sharing, and other infrastructure in place prior to WPC.

Care coordination staffing that meets patient needs. Staffing varied across and within WPC Pilots based on target population(s) and identified needs. Care coordination services were often provided by non-clinical staff such as community health workers. Due to the complexity of enrollee care needs, however, all care coordination teams included at least some staff with clinical expertise (e.g., providers, nurses, social workers). Many WPC Pilots also used peers with lived experience (e.g., previously incarcerated or homeless peers) to help build trust and rapport with enrollees. Staff workload varied considerably across WPC Pilots depending on projected acuity of the target population and intensity of contact with enrollees.

Data sharing capabilities to support care coordination. WPC Pilots were required to develop new data sharing capabilities. By 2018, all 25 WPC Pilots had at least some formal data sharing agreements with key partners. Many had developed universal consent forms for sharing patient data, and nearly all used an electronic data sharing platform that included information on comprehensive care plans. WPC Pilots that did not yet have these capabilities reported challenges such as vendor delays and difficulty obtaining partner buy-in. Yet they typically had temporary solutions to facilitate data sharing (e.g., ShareFile, SharePoint, Box) until more efficient and permanent systems could be procured or implemented. Over half of WPC Pilots reported successfully sharing comprehensive medical, behavioral health, and social services data with partners. Pilots that did not yet share behavioral health data typically identified federal confidentiality laws protecting the privacy of substance use disorder patient records (42 CFR Part 2) as a major barrier. Less than half of WPC Pilots reported providing frontline staff with real-time notifications about patient events, such as emergency department visits, but most WPC Pilots without this capability identified developing real-time notifications as a future priority.

Standardized organizational protocols to support care coordination. Around half of WPC Pilots had standardized protocols in place for referring enrollees to needed services (e.g., checklists) and tracking or following up with enrollees to assess referral outcomes. Several WPC Pilots cited the heterogeneity of enrollee service needs as a barrier to developing standardized referral protocols, particularly when referral processes were not integrated with an existing electronic platform to facilitate tracking. Pilots that contracted out care coordination services to multiple partners also cited partner preferences for developing and maintaining their own internal protocols as a barrier to standardization.

Financial incentives to promote cross-sector care coordination. Pilots were primarily reimbursed for care coordination under WPC using per-member, per-month (PMPM) payments for a bundle of services, though some received fee-for-service reimbursement to deliver additional services (e.g., outreach and engagement, assessments and screening). Eleven WPC Pilots stratified their PMPM bundles based on enrollee acuity or risk and tailored service intensity. The majority contracted with one or more external organizations (e.g., local health clinics or private social services providers) to supply some or all of their care coordination services. Of these, over half included financial incentives in contracts linked to the achievement of specific outcomes aligned with WPC goals (e.g., improving quality of documentation or scheduling a follow-up primary care visit within 7 days of hospital discharge).

Care Coordination Processes

WPC Pilots also reported significant progress in implementing key processes necessary

Care Coordination Processes in WPC Pilots

Exhibit 3

Care coordination framework element	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa	Mendocino	Monterey	Napa	Orange	Placer	Riverside	Sacramento	San Benito	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura	Total Pilots
Care coordination processes																											
Ensure frequent communication and follow-up to engage patients																											
Enrollee contact more than once per month	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Field-based outreach	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Frequent in-person, on-going communication with enrollees	•	•		•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•		•	•	•	•	•	23
Conduct needs assessment and develop comprehensive care plan																											
Needs assessment more than once per year	•		•	•	•		•		•	•			•	•	•		•	•	•		•			•		•	16
Single shared care plan	•	•		•	•	•	•	•		•	•	•	•	•	•		•	•			•		•	•	•	•	20
Actively link patients to needed services across sectors																											
Active referral to medical care	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Active referral to behavioral health care	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Active referral to social services	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26
Promote accountability within the care coordination team																											
Regular meetings with team to promote accountability	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	25

Data Source: WPC applications, mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services, interviews conducted with representatives of each Pilot from September 2018 to March 2019, and surveys of WPC organizations administered in the summer and fall of 2018.

for effective cross-sector care coordination (Exhibit 3). Their specific approach to these processes varied largely due to their WPC Pilot's target populations and the level of intensity of services they aimed to provide.

Ensure frequent communication and follow-up to engage patients. Many WPC Pilots required care coordinators to contact enrollees at least once per month. However, care coordinators in nearly all WPC Pilots reported contacting enrollees more frequently based on patient need. Most also reported using and prioritizing in-person outreach in the field rather than contacting enrollees by telephone. WPC Pilots described field-based outreach as particularly important for identifying and engaging homeless enrollees.

Assess patient needs and develop a comprehensive care plan. WPC Pilots were required to assess enrollee needs and develop a comprehensive care plan within 30 days of enrollment in WPC and, when appropriate, to repeat this process at least once per year. In practice, most WPC Pilots required care coordinators to re-assess enrollee needs and update care plans more frequently. To assist with accurate identification of needs, many WPC Pilots reported the use of validated instruments such as the Vulnerability Index—Service Prioritization Decision Assistance Tool and the Patient Health Questionnaire-9.

Actively link patients to needed services across sectors. All WPC Pilots reported use of active referral processes such as accompanying enrollees to appointments or facilitating

"Field-based outreach was particularly important for identifying and engaging homeless patients."

"Continued investment in data sharing capabilities, staff training, and other infrastructure are needed to support effective cross-sector care coordination."

warm hand-offs to medical, behavioral health, and social service providers. WPC Pilots reported perceived benefits of active referral to include the ability to ensure enrollees received important services, provide immediate follow-up after service receipt, and create additional opportunities for care coordinators to interact with enrollees and monitor enrollee needs and progress. Among WPC Pilots without standardized protocols for referral tracking and follow-up, active referral strategies were viewed as critical for helping informally "close the loop" on referrals.

Promote accountability within the care coordination team. WPC Pilots were required to identify providers and staff responsible for care coordination. Almost all WPC Pilots reported use of regular team meetings to keep one another informed of enrollee progress and promote accountability for care coordination activities. A number of WPC Pilots also reported regular case conferences or other opportunities to share challenges and brainstorm potential solutions. Accountability was generally described as more challenging in WPC Pilots where responsibility for care coordination was distributed across many partners. In these WPC Pilots, challenges included lack of consistency in care coordination activities, the potential for enrollees to have multiple designated care coordinators across different organizations, and a greater need for careful communication during hand-offs across organizations.

Future Steps

Our interim examination showed many WPC Pilots made significant progress in building needed infrastructure and delivering cross-sector care coordination services. By mid-2018, many WPC Pilots had successfully hired care coordinators, shared data across sectors despite multiple challenges, created standardized protocols to support care coordination activities, and built financial incentives for performance into contracts with providers. Many WPC Pilots also established care processes to engage enrollees in care, developed comprehensive care plans, actively linked patients to needed services, and promoted accountability among care coordination teams. All Pilots described WPC as an important opportunity to improve cross-sector relationships and build more effective systems of care within their communities.

The implementation of WPC included significant and numerous challenges. Pilots acknowledged the need for further progress in multiple areas to achieve overarching WPC goals of better care, better health, and better efficiency. Our analyses identified specific strategies to address these challenges:

Invest more time to further develop the infrastructure to support cross-sector care coordination. Many WPC Pilots had limited or no cross-sector data sharing capabilities prior to WPC. Pilots that successfully created this infrastructure reported investing a significant amount of time, typically more than originally anticipated, to accomplish their goals within the first few years of implementation. Universal consent forms facilitate information sharing, but WPC Pilots noted the need to plan significant time for review by legal counsel in different organizations. WPC Pilots located in counties in which the majority of services were contracted out to private agencies emphasized the importance of allocating sufficient time to ensure partner buy-in and to align financial incentives within contracts with WPC goals. All WPC Pilots reported the importance of continued investment in data sharing capabilities, staff training, and other infrastructure needed to support effective cross-sector care coordination, even mid-implementation.

Promote person-centered practices that more effectively engage vulnerable patients in care. Pilots recognized the need for patient-centered outreach, communication, and referral strategies to engage enrollees in WPC services. Successful strategies reported by WPC Pilots to help foster enrollee self-efficacy included using case management in addition to care coordination to more effectively serve enrollees, the hiring of clinical staff that were only funded part-time by WPC to allow for direct provision of services as part of initial outreach and engagement efforts, and providing benefits assistance to help reduce Medi-Cal churn. All Pilots also reported ongoing adjustment of WPC programs (e.g., by reducing care coordinator caseloads or clarifying scope of work) to better meet enrollee needs.

Leverage WPC resources and partnerships to help address structural problems outside of WPC Pilots' control. Multiple WPC Pilots cited limited availability of long-term, permanent housing as a barrier. Similarly, several small and rural counties cited difficulties with recruitment and retention of staff and limited availability of private behavioral health providers accepting Medi-Cal as barriers to timely access to behavioral health services. Strategies used by some WPC Pilots to address this issue included leveraging WPC to ensure expedited access or priority placement for their enrollees and developing innovative partnerships to improve availability of services within the community, e.g., working with private homeowners to place people in new types of housing.

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Data and Methodology

UCLA developed the care coordination framework following a systematic review of the literature on cross-sector care coordination. Screening of 1,694 articles identified 27 articles addressing interventions to coordinate health and social services for high-use patient populations. These articles were evaluated for key themes and trends and directly informed the conceptual framework used in this report. Qualitative data sources used to assess WPC Pilot care coordination activities included WPC applications, mid-year and annual narrative reports submitted by WPC Pilots to the California Department of Health Care Services, semi-structured interviews conducted with key informants from each Pilot between September 2018 to March 2019 (n=27), and web-based surveys administered from July 2018 to October 2018 to key program staff in WPC Pilot Lead Entities (n=27) and Partners (n=227). UCLA coded reports and interviews for themes by multiple coders to ensure validity. Analysis were completed using NVivo 12.0 software. Analysis of survey data was completed using Excel and Stata 13.1.

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Endnotes

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Appendix M: Care Coordination Case Studies

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Alameda County

Connie Lu, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Alameda County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Alameda County Health Care Services Agency (HCSA) worked most closely with multiple county agencies (Behavioral Health Care Services, Community Development Agency, Emergency Medical Services, and Health Care for the Homeless), eight community partners, and two managed care plans (Anthem Blue Cross and Alameda Alliance for Health).

Eligible enrollees were identified using administrative data from partners, and successfully enrolled after being contacted by a community partner providing either a service bundle or a discrete service. Some enrollees received occasional discrete services as needed, while others were enrolled in more intensive service bundles for an average of 6 to 12 months and graduated from WPC once they had achieved their goals.

The overall characteristics of Alameda's WPC Pilot called "Alameda County Care Connect" are displayed in Exhibit 1.

Exhibit 1: Alameda WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">Alameda County Health Care Services Agency</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">17,000</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Administratively Enrolled</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers, Homeless</td></tr>
<tr><td colspan="4">35 Partner Organizations</td></tr>
<tr><td>12 County Health and Mental Health</td><td>2 County Housing, Justice, or Social Services</td><td>3 Managed Care Plan</td><td>18 Community Partners[1]</td></tr>
</table>

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Alameda focused on improving housing support, 30-day follow-up after psychiatric emergency services, high blood pressure control, and depression remission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Intensive care coordination services were provided primarily through the Care Management Service Bundles by community health workers (CHWs) supported by multidisciplinary teams of diverse specialists (e.g., nurses, social worker staff, primary care provider, and housing coordinators). Similar care coordination was also provided in the housing-related service bundles led by housing coordinators. Many CHWs and housing coordinators had personal lived experience similar to that of WPC target populations to help improve enrollee engagement. The caseload goal for CHWs was typically 30-35 enrollees, but in practice was closer to 20-25 depending on the community partner providing the service due to the time requirements that were more intensive than expected. Caseloads for the housing-focused service bundles ranged from 20-30.

Data sharing capabilities to support care coordination. By early 2019, Alameda County HCSA had executed data sharing agreements with some of its partners, including other county agencies, hospitals, community clinics, health plans, mental health and substance use treatment providers, and housing provider organizations. Alameda's Pilot also implemented a release of information form for eligible enrollees, but did not have a universal consent form used by all partners.

As part of WPC, Alameda's Pilot planned to launch a community health record (CHR) that would be used by all WPC partners to share relevant enrollee data. By early 2019, the Pilot had established a prototype CHR that was used by eight partner organizations. Features of the prototype CHR included a shared communication space, access to the care plan, and enrollment and eligibility data. Users of the CHR were also able to access shared data in real-time and in the field. WPC partners who did not use the prototype CHR typically utilized their own electronic systems to store and access enrollees' care plan. Alameda's Pilot planned to launch the permanent CHR, including shared housing and social services data, by late 2019 and substance use disorder data by 2020.

Standardized organizational protocols to support care coordination. Alameda's Pilot included standardized protocols for referring enrollees to needed services. Protocols were developed by the Pilot's training program (called the Care Connect Academy), which was responsible for training participating providers and staff to effectively meet the needs of WPC enrollees. As of early 2019, Care Connect did not have standardized protocols for monitoring referral status and follow-up documentation, but was exploring this functionality for later additions to the CHR.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided through contracts with external service providers, rather than directly by HCSA. Alameda County HCSA was reimbursed for care coordination services using two, risk-stratified per-member-per-month (PMPM) bundles under the Care Management Service Bundle: Tier 1 moderate-intensity care coordination and Tier 2 high-intensity care coordination for those with serious mental illness and/or experiencing homelessness. HCSA was reimbursed for care coordination as a part of the housing-related service bundle using three risk-stratified tiers. External partners were also paid on a fee-for-service basis for discrete services and received financial incentives for achieving identified outcomes. For example, partners were provided incentive payments for achievements such as improving access and quality of care for WPC enrollees, and improving electronic data collection and reporting.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Alameda's Pilot utilized a person-centered approach for communicating with enrollees. Initial contact was made in the field wherever enrollees could be found (e.g., hospital, at their homes, in homeless encampments, on the street, and other

locations). Ongoing communication primarily occurred face-to-face with a reported average of three times per month. The Pilot identified in-person outreach as critical for enrollee engagement.

Conduct needs assessments and develop comprehensive care plans. CHWs performed a formal needs assessment of physical health, behavioral health, and social needs (e.g., housing) at intake into the care management service bundle, and updated with additional assessments throughout the year as appropriate. Needs assessment results were used to develop a comprehensive care plan with enrollee-driven goals electronically accessible to providers (either via the CHR or a partner organization's internal EHR or case management platform).

Actively link patients to needed services across sectors. Alameda's WPC CHWs used active referral strategies to refer their enrollees to needed services. All staff involved in care coordination received training through the Care Connect Academy on how to effectively link enrollees to needed services across the system of care, particularly primary care. Depending on the needs of the particular enrollee, this included scheduling follow up appointments, arranging for transportation, and attending those appointments alongside the enrollee, when appropriate.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team providing the housing-related service bundle, Alameda's Pilot required multidisciplinary care coordination teams to participate in two-hour, bi-weekly case conferencing meetings. At each meeting, teams discussed the needs and concerns of approximately 50 of the most vulnerable enrollees. Additional providers from other sectors were encouraged to join to support linkages across the system of care.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Contra Costa County

Leigh Ann Haley, MPP, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Contra Costa County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Contra Costa Health Services (CCHS) worked most closely with Employment and Human Services, one managed care plan, one regional medical center, and three community partners.

Eligible enrollees were identified using a predictive risk model that drew on linked data from multiple sources (e.g., medical records from clinics and hospitals, claims from the health plan and outside providers, the Sheriff's Department, and the County Public Health Agency's case management system). Enrollees were evaluated at 12 months for continued services or graduation.

The overall characteristics of Contra Costa's WPC Pilot called "CommunityConnect" are displayed in Exhibit 1.

Exhibit 1: Contra Costa WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">Contra Costa Health Services (CCHS)</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">42,000</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Predictive Risk Modeling with Two Risk Levels</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers</td></tr>
<tr><td colspan="4">11 Partner Organizations</td></tr>
<tr><td>4 County Health and Mental Health</td><td>1 County Housing, Justice or Social Services</td><td>1 Managed Care Plan</td><td>5 Community Partners[1]</td></tr>
</table>

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that are not part of the lead entity's organization.

To achieve the goals of better care and health, Contra Costa's WPC Pilot focused on developing patient-centered care plans. The Pilot reported on improvement in self-reported health status and quality of life, suicide risk assessment and depression remission rates, and SBIRT screening rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. CCHS hired 150 staff for WPC, all with offices in a central location specifically dedicated to WPC. Care coordination services were provided by multidisciplinary teams led by supervisors. Each team was organized to include diverse specialists (e.g., public health nurses, mental health counselors, substance abuse counselors, community health workers (CHWs)). The Pilot included some care coordinators with personal lived experience similar to that of WPC target populations to help improve enrollee engagement. Housing and tenancy support services were provided directly by care coordinators. However, the Pilot also contracted with the Employment and Human Services division to hire three Social Service Agency Eligibility Specialists to assist with applications to public benefits and twelve social workers to assist enrollees with navigating other benefits (e.g., in-home supportive services). Expansion plans in 2019 included the addition of four social workers specializing in the area of In-Home Supportive Services.

Tier 1, or high risk, enrollees were assigned to a single care coordinator whose specialty was best aligned with the enrollee's needs and received field-based services. Tier 2, or lower risk, enrollees were typically assigned to a CHW and received telephonic care coordination services. However, ownership and responsibility for all enrollees was shared across the multidisciplinary team, and care coordinators could request consults from other members of their interdisciplinary team when needed.

In early 2019, the average caseload was 90 clients for care coordinators working with Tier 1 enrollees and 350 clients for care coordinators working with Tier 2 enrollees. With the introduction of a WPC budget modification in late 2018, CCHS reported plans to reduce the caseloads to 80 and 250 for care coordinators working with Tier 1 and Tier 2 enrollees, respectively.

Data sharing capabilities to support care coordination. By early 2019, CCHS executed data sharing agreements with all of its partners, including the County Employment and Human Services agency. To facilitate data sharing, Contra Costa relied on a universal consent form among all WPC partner organizations.

All key WPC partners utilized the same electronic health record, Epic, which greatly streamlined data sharing efforts. Linked data available in Epic were comprehensive, and included medical data from clinics and hospitals, behavioral health data from the County Behavioral Health Department, and data from Public Health. Additional data from outside providers, including the Sheriff's Department and social services data from the Homeless Management Information System, were included in workflows with integration via the county's data warehouse.

Care coordinators used Epic to record and track daily activities, monitor enrollee progress, communicate with providers, and develop dashboards and reports to monitor metrics. To help promote a person-centered approach to enrollee engagement, care coordinators were able to access Epic on mobile laptops or other devices in the field. Care coordinators also received real-time notifications if enrollees visited the Emergency Department (ED), or were admitted to an inpatient setting or the County's detention facility.

Standardized organizational protocols to support care coordination. Contra Costa's Pilot included standardized protocols for referring enrollees to needed services, monitoring referral status, and documenting any follow-up. Behavioral health service referrals were coordinated via the Behavioral Health Access Line, a call center that enters and processes all behavioral health service referrals in the county.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided directly by CCHS, rather

than through contracts with external service providers. CCHS was reimbursed for WPC care coordination services primarily through two per-member per-month (PMPM) bundles that paid a set amount per enrolled person.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Contra Costa's Pilot initiated outreach via welcome letters and phone calls to eligible enrollees. Direct field outreach was utilized to contact hard-to-reach individuals. The majority of ongoing communication with Tier 1 enrollees occurred via in-person field visits (e.g., home, community space, shelter, library, doctor's office) that took place between one and three times per month. For Tier 2 enrollees, all communication was telephonic and occurred at least every two months. Care coordinators were expected to follow-up on high-risk notifications (e.g., ED utilization) within 72 hours of receipt.

Conduct needs assessments and develop comprehensive care plans. Care coordinators initiated a formal needs assessment at intake and completed the process in the first few weeks or months of enrollment. The Pilot used an interactive process to develop a comprehensive care plan with client-driven goals that often evolved over the enrollment period. Comprehensive care plans were maintained in Epic and accessible to all key WPC partners.

Actively link patients to needed services across sectors. Contra Costa's WPC care coordinators used active referral strategies to refer their enrollees to needed services, particularly those in Tier 1. For example, all care coordinators either directly scheduled medical appointments for enrollees or actively taught enrollees how to schedule their own appointments using an advice nurse or online portal. Care coordinators were required to refer enrollees to the Behavioral Health Access Line to make appointments for behavioral health services, but reported arranging these appointments jointly with enrollees when needed. In addition to medical and behavioral health resource referrals, WPC care coordinators also had access to a comprehensive social resource database which they used to provide resource referrals. These referrals were then tracked and followed up through their Epic care plan.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Contra Costa's Pilot required in-person, bi-monthly meetings for multidisciplinary teams and specialties (e.g., Public Health nurses). Multidisciplinary team members were also deliberately co-located in the same office space to promote communication and accountability.

Suggested Citation

Haley LA, Chuang E, Albertson E M., Lu C, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Contra Costa County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Kern County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) pilot program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Kern County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Kern Medical Center (KMC) worked most closely with three county agencies (Housing Authority, Department of Human Services and the Sherriff's Office), two managed care plans, and four community partners.

Eligible enrollees were initially identified using lists of individuals meeting target population criteria from two local health plans. However, the Pilot found that these lists did not contain current contact information and were not successfully identifying individuals that were homeless or at-risk-of-homelessness, or those that were recently incarcerated or soon-to-be-released. Therefore, the Pilot updated their enrollment strategy to a referral-based system from the housing authority and a jail-based physician.

Enrollees were asked to complete a six-course series (for the foundational WPC Care Coordination bundle) aimed to prepare them to coordinate their own care before assessing their readiness to graduate from the program.

The overall characteristics of Kern's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Kern WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">Kern Medical Center (KMC)</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">2,000</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Health Plan Administrative Data, Referrals</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers, Homeless, At-Risk-Of-Homelessness, Justice-Involved</td></tr>
<tr><td colspan="4">15 Partner Organizations</td></tr>
<tr><td>3 County Health and Mental Health</td><td>5 County Housing, Justice or Social Services</td><td>2 Managed Care Plan</td><td>5 Community Partners[2]</td></tr>
</table>

Notes: [1]Initially enrollment was based on administrative data, but later switched to a referral-based system [2]Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that are not part of the lead entity's organization.

To achieve the goals of better care and health, Kern's WPC Pilot focused on improving blood pressure and diabetes control, suicide risk assessment and depression remission rates, successful housing and supportive housing, and hospital readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. At Kern, care coordination services were provided by KMC medical assistants, supported by two physician champions, a social worker, a nurse practitioner, a PharmD, and a team of health educators. To promote continuity, medical assistants were responsible for outreach, enrollment, and provision of care coordination services. Caseloads for medical assistants varied depending on the type of enrollees they were assigned, but were typically no more than 125-150.

Data sharing capabilities to support care coordination. By early 2019, the Pilot had data sharing agreements in place with some but not all partners. Many community-based partners were described as reluctant to use KMC's data systems in lieu of their own, established data systems. Despite this challenge, Kern's Pilot was able to successfully develop a universal consent form used by all partners. The Pilot held enrollee care plans in KMC's electronic medical record. Due to limited data sharing across partners, not all partners were able to access or view the care plan.

Care coordinators used KMC's electronic health record and associated care coordination software to track and monitor referrals, access enrollee data, and update enrollee records to reflect WPC activities. However, care coordinator access to enrollee data was limited and did not include all relevant behavioral health and social services data. Care coordinators also did not have real-time notifications of emergency department visits or remote access to data.

Standardized organizational protocols to support care coordination. Kern's WPC Pilot used standardized protocols to make, track, and monitor referrals. Referrals for social services were made by care coordinators, while all medical and behavioral health referrals were made by clinicians and followed-up on by the care coordinators. Care coordinators followed protocols in the Pilot's care coordination software to track and close the loop on all referrals.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided by KMC, and funded primarily via two per-member-per-month (PMPM) bundles: 1) the WPC Care Coordination bundle and 2) the 90-Day Post-Incarceration Coordination bundle. The WPC Care Coordination bundle entailed care coordination by a multi-disciplinary team to address physical, behavioral health, and social service needs. The 90-Day Post-Incarceration bundle was specifically designed for individuals recently released from jail and services were tailored to meet specialized needs of this population, including specific courses geared around relevant topics for post-incarcerated enrollees, such as family reunification, recidivism reduction, and job readiness.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Care coordinators were responsible for outreach to potential enrollees at community events and/or by following up on referrals from partners. A physician co-located at the jail was responsible for outreach to potential enrollees prior to release from incarceration and connecting them to a medical assistant. Most contact for health plan referrals was telephonic, but the Pilot also tried to create opportunities for care coordinators and clients to meet in-person. Enrollees were assessed for their acuity level, which determined the frequency of ongoing communication: ranging from monthly for the lowest acuity level to weekly for the highest acuity level.

Conduct needs assessments and develop comprehensive care plans. Care coordinators

did not directly conduct needs assessments but were instead responsible for setting up appointments with a primary care physician and a social worker. At these appointments, the clinicians were responsible for performing a comprehensive biopsychosocial assessment. Assessment results were used to identify enrollee's physical, behavioral health, and social service needs, and served as the basis for developing a comprehensive care plan. Some assessments, including the PHQ-9 were repeated quarterly to track enrollee progress. Care plans were not standardized and could vary based on enrollees' needs. Only partners with access to KMC's medical record could view the care plan.

Actively link patients to needed services across sectors. Care coordinators in Kern provided active referrals for medical, behavioral health, and social services. For example, once enrolled, care coordinators were responsible for helping schedule a primary care appointment for every enrollee and for all other medical referrals ordered through the electronic medical records. Care coordinators were also permitted to directly schedule appointments with partnering behavioral health providers. All referrals made to partners external to KMC were kept as notes in the enrollee's medical record and were tracked using the Pilot's care coordination software.

Promote accountability within care coordination team. To promote accountability, the WPC manager checked in with staff at least daily and held a weekly WPC meeting where the care coordination team could openly discuss enrollment, goals, and challenges. Additionally, the team communicated regularly through email.

Suggested Citation

O'Masta B, Chuang E, Albertson E M., Lu C, Haley LA, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Kern County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Kings County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Kings County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Kings County Human Service Agency (HSA) worked most closely with two county agencies (Behavioral Health and Public Health) and one community partner (a non-profit behavioral health and social service provider).

Eligible enrollees were identified using a referral system, including self-referrals. A multidisciplinary team met with each prospective enrollee to assess needs, determine eligibility for WPC services, and assign an ongoing care coordinator. Enrollees typically stayed in the program for 4-12 months or until they achieved their care goals.

The overall characteristics of Kings' WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Kings WPC Pilot Overview

Lead Entity		Kings County Human Service Agency (HSA)	
5-Year Projected Enrollment		600	
Enrollment Strategy		Referrals-Based System	
Primary Target Population(s)		Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder	
8 Partner Organizations			
2 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	3 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, alcohol and other drug dependence, and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Kings' WPC Pilot focused on reducing untreated severe mental illness and substance use disorders, increasing assessments of suicide risk, decreasing jail recidivism, and improving chronic care management.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by care coordinators with varied backgrounds and experience (e.g., social work,

substance abuse counseling, on-the-job training through WPC only). There were also two acute care coordinators, who specialized in mental health counseling and were responsible for providing care coordination services to the highest acuity enrollees. The caseloads for acute care coordinators and general care coordinators were kept deliberately low at 10 and 20 enrollees, respectively, to ensure care coordinators had adequate time to work closely with enrollees.

Care coordinators also had access to support from a larger, multidisciplinary team (MDT) that included a housing navigator, job navigator, community health worker, and eligibility specialist. The eligibility specialist was responsible for working with enrollees to ensure they could access all public assistance they were qualified for (e.g., adult protective services and/or in-home supportive services). Kings also developed a peer specialist role using individuals with lived experience to help outreach and engage homeless enrollees.

Data sharing capabilities to support care coordination. By early 2019, Kings County HSA had executed data sharing agreements with most partners. To facilitate data sharing, the Pilot implemented a universal consent form among all WPC partner organizations. For enrollees experiencing homelessness, an additional, separate consent form was still required by the local Coordinated Entry System (CES), which was not a WPC partner organization.

The Pilot provided all partner organizations with access to an electronic case management platform (called ETO) to view enrollees' comprehensive care plans. Care coordinators used ETO to perform and track all care coordination activities. Data included in ETO was comprehensive, and included medical, behavioral health, and social services data from the county's behavioral health and human services agencies and the community-based partners responsible for care coordination. Care coordinators could access the system in the field, but did not receive any real-time updates about enrollee service utilization.

Standardized organizational protocols to support care coordination. Kings' Pilot included standardized protocols for referring enrollees to medical, behavioral health services, and social services. To monitor and follow-up on referrals, the Pilot relied on weekly status reports from the hospital and required care coordinators to directly contact partner organizations to check on referral status.

Financial incentives to promote cross-sector care coordination. The majority of care coordination services were contracted out to a single community partner, which was funded primarily through a per-member-per-month (PMPM) bundle. High acuity care coordination was provided by the county behavioral health department and was funded through a second PMPM bundle. The Pilot also received fee-for-service reimbursement for initial outreach and engagement of enrollees.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Kings' Pilot used in-person outreach to engage potential enrollees, including office, home, and community visits. Community visits included weekly visits at a church that served food to the underserved and homeless. Once enrolled in the program, care coordinators typically continued to contact enrollees at least once per week in-person, via telephone, or out in the community.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Specifically, a comprehensive needs assessment was typically conducted by a community health worker, care coordinator, and eligibility specialist. Results were reviewed by the MDT to determine eligibility for WPC, set preliminary care plan goals, and assign a care coordinator. Prospective enrollees were still not officially enrolled in WPC until after the care coordinator convened an initial care plan meeting including

all cross-sector care providers already working with the enrollee. Care coordinators were responsible for uploading the care plan in ETO and continued to screen enrollees every six months to update the care plan, set goals, and/or determine when enrollees were eligible for graduation from WPC.

Actively link patients to needed services across sectors. Kings' WPC care coordinators used active referral strategies to refer their enrollees to needed services. For example, care coordinators tailored service recommendations based on enrollees' past experiences with local service providers and facilitated access to a primary care physician if enrollees did not already have a usual source of care.

Promote accountability within care coordination team. In order to increase accountability within the care coordination team and facilitate communication between multidisciplinary team members, care coordinators and the MDT were located in close proximity to one another in the same office. Care coordinators were able to access specialized knowledge of the MDT, which met weekly to discuss enrollee needs and progress.

Suggested Citation

O'Masta B, Chuang E, Albertson E M., Lu C, Haley LA, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Kings County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Los Angeles County

Leigh Ann Haley, MPP, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Los Angeles County WPC Pilot using this framework from implementation to March 2019.

Background

The Los Angeles County Department of Health Services (LACDHS) worked with over 100 organizations within the County to implement WPC. LACDHS worked most closely with five county agencies (Mental Health, Public Health, Public Social Services, Los Angeles Sheriff Department, and Probation), two managed care plans (LA Care and Health Net), and multiple social service agencies.

WPC-LA implemented 16 programs designed for six different target populations. These programs included Homeless Care Supportive Services, Medically Complex Transitions of Care, Recuperative Care, and Community Re-entry, and more; 15 of these 16 programs included at least some care coordination services. Eligible enrollees were identified using an open referral process. Length of enrollment varied depending on the program clients qualified for, but services were largely designed to be transitional (i.e., average program duration between 1-4 months though could go as high as 9-12 months for high acuity enrollees).

The overall characteristics of Los Angeles' WPC Pilot called "WPC-LA" are displayed in Exhibit 1.

Exhibit 1: Los Angeles WPC Pilot Overview

<table>
<tr><td>Lead Entity</td><td colspan="3">Los Angeles County Department of Health Services (LACDHS)</td></tr>
<tr><td>5-Year Projected Enrollment</td><td colspan="3">140,146</td></tr>
<tr><td>Enrollment Strategy</td><td colspan="3">Referrals</td></tr>
<tr><td>Primary Target Population(s)</td><td colspan="3">High Utilizers, Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness, Justice Involved</td></tr>
<tr><td colspan="4">114+ Partner Organizations</td></tr>
<tr><td>2 County Health and Mental Health</td><td>6 County Housing, Justice, or Social Services</td><td>6 Managed Care Plans</td><td>100+ Community Partners[1]</td></tr>
</table>

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, WPC-LA focused on permanently housing homeless enrollees, reducing jail recidivism, and decreasing 30-day all-cause readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by community health workers (CHWs) under the supervision of licensed clinical social workers. WPC-LA deliberately included CHWs with personal lived experience similar to that of WPC target populations to help improve enrollee engagement. Caseload varied by program and ranged from 15-40 enrollees depending on enrollee acuity and expected level of engagement.

Data sharing capabilities to support care coordination. For all formal WPC partnerships, LACDHS created a Business Associate Agreement (BAA) that included a data-sharing element, and required all formal WPC partners to sign the BAA to participate. WPC-LA also created a segmented universal consent form used by all partners, which allowed enrollees to elect out of sharing particular elements if they wished (e.g., data covered by 42 CFR (Code of Federal Regulations) Part 2, mental health history, HIV test results).

WPC-LA developed a real-time case management platform, Comprehensive Health Accompaniment and Management Platform (CHAMP), specifically for WPC. The main purpose of the platform was to facilitate workflows for frontline staff (e.g., eligibility screens, enrollment and assessments, creation of a care plan with "SMART" goals), store enrollee documents (e.g., universal consent form), and comprehensively document case related information (e.g., updated care plan, attempted contacts with enrollees, case notes). CHWs could access CHAMP remotely while in the field.

Most WPC-LA staff had access to CHAMP, as well as staff in the Office of Diversion and Re-entry, Housing for Health, Countywide Benefits Entitlement Services Team, and Intensive Case Management Service providers.

As of fall 2018, CHAMP did not yet exchange data or interface with other electronic systems, though LACDHS ultimately planned to implement a comprehensive data system with real-time feeds from multiple sources. Ideally, they aimed to include data from county Health Services, Social Services, Mental Health, Public Health (DPH), Housing for Health, jails/Sheriff's Department, courts, and managed care plans.

Standardized organizational protocols to support care coordination. Los Angeles' Pilot included standardized protocols around patient assessment and care plan development. As of fall 2018, the Pilot had not yet developed standardized protocols for making social services referrals and monitoring referral status, but had plans to implement protocols in the future. To help facilitate that process, in 2018 WPC-LA began utilizing a mobile community resource platform called OneDegree.

Financial incentives to promote cross-sector care coordination. WPC-LA services were reimbursed using 15 different per-member-per-month (PMPM) bundles and one fee-for-service (FFS) bundle, each corresponding to a different WPC–LA program. WPC-LA funded additional programs through incentives. For most WPC-LA programs, LACDHS either (1) created new county positions and hired staff to deliver services in-house; or (2) contracted with community partners to deliver the service.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Los Angeles' Pilot used a variety of settings and modes to initiate contact with eligible enrollees across WPC-LA programs (e.g., in hospitals for transitions of care, etc.). The most common form of outreach was in-person, by meeting enrollees where they were (e.g., in hospital or at primary care visit). CHWs maintained contact with enrollees

through a variety of mechanisms, but primarily by a mix of telephone and in-person visits.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake; the primary goal of the first CHW-enrollee visit was to assess enrollee needs and to build trust. WPC-LA developed an "in-house" needs assessment tool that CHWs accessed through CHAMP. The assessment, which included validated instruments, captured medical, social determinants of health, mental health and substance use disorder (SUD) history, and food insecurity. As appropriate, care coordinators also used the Vulnerability Index - Service Prioritization Decision Assistance Tool to provision housing support services. Results of the needs assessment were used to develop a person-centered care plan, which CHWs were required to update regularly.

Actively link patients to needed services across sectors. WPC-LA's CHWs used active referral strategies to refer their enrollees to needed medical care, behavioral health care, and social services. For example, CHWs were described as frequently accompanying enrollees to appointments.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, WPC-LA required the CHWs to participate in weekly meetings with their supervisor. Supervisors were expected to review case notes and care plan progress, and discuss strategies for supporting high-need clients with CHWs. In addition, when not in the field, teams were centrally located at Regional Coordinating Centers to facilitate face-to-face meetings, sharing of lessons learned, and urgent consultations amongst care coordination teams, as needed.

Suggested Citation

Haley LA, Chuang E, Albertson E M., Lu C, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Los Angeles County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Marin County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) pilot program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Marin County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Marin County Department of Health and Human Services (HHS) worked most closely with county agencies (Health and Human Services: Behavioral Health and Recovery Services, and the Marin Housing Authority), one managed care plan, six community partners providing contracted WPC case management (including three out of four of Marin's federally qualified health centers) and a number of other community partners.

Eligible enrollees were identified using administrative data from the county's Coordinated Entry System. The Pilot also accepted referrals from community health clinics. The Pilot prioritized enrollment of the top 10% of Medi-Cal beneficiaries based on emergency department utilization that also were homeless, had complex medical conditions, had behavioral health issues, and/or lacked social supports identified as interfering with adherence to treatment. Length of enrollment in the program varied depending on the services needed by the client.

The overall characteristics of Marin's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Marin WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">Marin County Department of Health and Human Services (HHS)</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">3,200</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Administrative Data and Referrals</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers, Homeless, At-Risk-of-Homelessness</td></tr>
<tr><td colspan="4">29 Partner Organizations</td></tr>
<tr><td>2 County Health and Mental Health</td><td>4 County Housing, Justice, or Social Services</td><td>1 Managed Care Plan</td><td>22 Community Partners[1]</td></tr>
</table>

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that are not part of the lead entity's organization.

To achieve the goals of better care and better health, Marin's WPC Pilot focused on using assessments, improving housing support, and improving self-reported health status.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by care coordinators whose qualifications varied depending on the type of enrollees served. For example, care coordinators for medically complex enrollees were registered nurses supported by medical assistants. For enrollees with mild-to-moderate mental illness, the care coordinator was a licensed clinical social worker or social work student supervised by a licensed clinical social worker. Many housing care coordinators had lived experience similar to that of enrollees, which facilitated outreach and engagement. Care coordinator caseloads varied across organizations and by type of case management, ranging from 17 to 30 enrollees.

WPC enrollees could also receive additional support from dedicated benefit support specialists, housing support specialists, and physicians within WPC partner organizations.

Data sharing capabilities to support care coordination. By early 2019, Marin HHS had executed data sharing agreements with all partner organizations and was actively sharing medical, social service, and some behavioral health data through the county's health information exchange. To facilitate data sharing, Marin implemented a universal consent form that all WPC partner organizations used during enrollment.

Marin HHS also implemented an electronic care coordination platform to provide partners with access to enrollee data, including the comprehensive care plan, and help track care coordination activities. The platform included an internal messaging tool with chat functions to facilitate communication between providers. Care coordinators were able to access the platform in the office and in the field.

Standardized organizational protocols to support care coordination. Marin's WPC Pilot included standardized protocols to monitor and follow-up on key elements of care coordination, but the Pilot chose not to develop standardized service referral protocols. Rather, they provided intensive case management, which included connecting clients to and with any services judged necessary.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided through contracts with external providers, and specifically with local community partners. The Pilot's care coordination services were funded primarily through three per-member per-month (PMPM) bundles: a housing-based case management bundle, a comprehensive case management bundle and a case management bundle for individuals with mental health conditions and complex psycho-social challenges but do not meet criteria of severe mental illness for County Behavioral Health Services. Enrollees were placed into service bundles based on primary need rather than acuity. The Pilot also received fee-for-service reimbursements for care management referrals, screening and assessments, housing support, engagement, and care plan development. Partners received financial incentives for achieving specific outcomes, such as developing a comprehensive care plan within 30 days of enrollment and ensuring high participation in case conferences.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Marin's WPC Pilot used a variety of methods to initiate contact with eligible enrollees, depending on the partner organization and enrollee needs. For example, initial contact with homeless enrollees typically occurred in the field, while initial engagement of medically complex enrollees typically occurred in the clinic. After enrollment in WPC, most communication between care coordinators and enrollees occurred in-person. On average, care coordinators contacted WPC enrollees 3.8 times per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, with a subset of assessments repeated annually.

Assessment tools included the Patient Health Questionnaire-9 or PHQ-9 for depression, a suicide risk assessment, and an assessment of social determinants of health. Care coordinators were required to work with enrollees to develop a care plan with person-centered goals. Care plans include at least one client-identified goal, and plans were updated frequently as enrollees met existing goals and identified new ones.

Actively link patients to needed services across sectors. Marin's WPC care coordinators used active referral strategies to refer their enrollees to needed services, including medical, behavioral health, and social services. For example, care coordinators often scheduled appointments for enrollees and accompanied them to their appointments. Active referral processes were described as successful in linking previously resistant enrollees to services. Dedicated staff to assist enrollees through the benefit enrollment and renewal process were also identified as an important resource for overcoming barriers to accessing care.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Marin's pilot required care coordinators to participate in bi-weekly case conferences. One partner used daily triage meetings to review previous day interactions with enrollees, schedule activities for the current day, and discuss questions related to enrollee care.

Suggested Citation

O'Masta B, Chuang E, Albertson E M., Lu C, Haley LA, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Marin County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: Mariposa County

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Mariposa County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Mariposa County Human Services Department (MCHSD) worked most closely with two county agencies (Behavioral Health Services and Employment and Community Services), the local health care district, two local managed care plans, and a community-based health and social services provider.

Eligible enrollees were identified through referrals from partner agencies and targeted outreach to managed care plan lists of high utilizers. Care coordinators were responsible for contacting potential enrollees to assess eligibility and schedule an initial meeting.

Mariposa's WPC Pilot was a member of the Small County Whole Person Care Collaborative (SCWPCC), along with San Benito.[1] Although counties in the collaborative shared some infrastructure and processes, each county's program was distinct.

The overall characteristics of Mariposa's Pilot are displayed in Exhibit 1.

Exhibit 1: Mariposa WPC Pilot Overview

Lead Entity		Mariposa County Human Services Department (MCHSD)	
5-Year Projected Enrollment		87	
Enrollment Strategy		Referrals and Targeted Outreach	
Primary Target Population(s)		High Utilizers, Severe Mental Illness and/or Substance Use Disorder	
10 Partner Organizations			
2 County Health and Mental Health	4 County Housing, Justice, or Social Services	2 Managed Care Plan	2 Community Partners[2]

Notes: [2] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Mariposa's WPC Pilot focused on improving suicide risk assessment rates, housing services, implementing a uniform housing

[1] Plumas County was initially a member of the collaborative, and subsequently ended their participation in WPC.

assessment tool, and reducing hospital readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a multi-disciplinary team, with care coordinators trained in mental health receiving support from a part-time licensed vocational nurse and nurse practitioner, and a housing navigation team comprised of staff with lived experience similar to that of WPC enrollees. Average care coordinator caseload was 20 to 25 enrollees.

Data sharing capabilities to support care coordination. By 2018, MCHSD executed data sharing agreements with all of its partners. To facilitate data sharing, Mariposa implemented a universal consent form among all WPC partner organizations.

MCHSD also implemented an integrated data management system called eWPC that contained medical, behavioral health, and social services information. All key partners were included in this integrated data sharing platform, except the local health care district which did not join the system due to the extensive resources required to learn and implement a new data platform. Care coordinators were trained in use of the new system. To help promote a person-centered approach to enrollee engagement, staff were provided tablets they could use to access the database in the field. Although most data was stored in eWPC, care coordinators reported that some data still needed to be manually collected from other sources, such as lab reports. Care coordinators did not receive real-time notifications if enrollees visited the hospital or emergency department. They received calls from staff at the time of the visit, though not consistently. Real-time notifications were a future goal of the eWPC system.

Standardized organizational protocols to support care coordination. Mariposa's WPC Pilot included standardized protocols for referrals using standardized checklists and protocols for administering assessments at intake. However, they had not yet developed a written protocol for monitoring and following up on referrals. A typical process was to review enrollee charts and act accordingly based on enrollee needs.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided directly by MCHSD, rather than through contracts with external service providers. However, housing navigation services were contracted out. MCHSD was reimbursed for WPC care coordination services primarily through a single per-member-per-month (PMPM) bundle that paid a set amount per enrolled person. A second PMPM bundle also funded the housing support services that were contracted out.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Mariposa's WPC Pilot mainly used in-person communication with enrollees, both during outreach and on-going communication. Care coordinators were expected to contact enrollees at least once per week. This approach was particularly important for engaging enrollees who were homeless.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Certain assessments, such as the Patient Health Questionnaire-9 or PHQ-9 depression screening, were repeated every six months or potentially even more often for enrollees with a high score. Care coordinators developed a single comprehensive care plan for each enrollee and this plan was shared with all relevant partners using eWPC. When the care plan was needed by partners not on eWPC, Mariposa developed a system that allowed them to share the care plan with these partners.

Actively link patients to needed services across sectors. Mariposa's WPC care coordinators used active referral strategies to refer their enrollees to needed services. Care

coordinators made appointments for enrollees by phone, and sometimes accompanied enrollees to appointments. The Pilot also established an arrangement with the local health care district to provide WPC enrollees with priority appointments.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Mariposa's WPC Pilot required care coordinators to meet regularly, including several times per month with supervisors and other administrators, in order to organize care for each enrollee and to work on improvement projects. The entire multi-county SCWPCC leadership group met quarterly.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Mariposa County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Mendocino County

Connie Lu, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Mendocino County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Mendocino County Health and Human Services Agency (HHSA) worked most closely with one administrative service organization (Redwood Quality Management Company) and three community partners (Adventist Health Ukiah Valley, Mendocino Coast Clinics and Mendocino Community Health Clinics).

Eligible enrollees were identified using referrals. The Pilot evaluated enrollees every 180 days to determine if the enrollee still needed WPC services. In January of 2019, the Pilot implemented a formal graduation system.

The overall characteristics of Menocino's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Mendocino WPC Pilot Overview

Lead Entity		Mendocino County Health and Human Services Agency (HHSA)	
5-Year Projected Enrollment		550	
Enrollment Strategy		Referrals	
Primary Target Population(s)		Severe Mental Illness and/or Substance Use Disorder	
10 Partner Organizations			
3 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	4 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Mendocino's WPC Pilot focused on restoring and strengthening the medical and social support system for individuals with severe mental illness and two other qualifying conditions, including substance use disorder, high utilizers of medical expenses, homelessness, or recent law enforcement contact. Specifically, the Pilot focused on improving care through housing support, improving health through increased control of diabetes and hypertension, and improving social connections.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by diverse, multidisciplinary teams that varied by enrollee but could include peer support workers with lived experience similar to that of enrollees (called "Wellness Coaches" by the Pilot), nurses, mental health counselors, housing and benefit support staff, substance abuse counselors, community health workers, social workers, and/or physicians or nurse practitioners as needed. Wellness Coaches typically served as the primary point of contact for enrollees and were responsible for outreach and engagement. The average caseload per wellness coach was 15-20 enrollees and was purposively designed to include a mix of higher acuity and lower acuity enrollees.

Data sharing capabilities to support care coordination. By early 2019, Mendocino County HHSA had executed data sharing agreements with all of its partners with the exception of the managed care health plan, where a data sharing agreement was pending. To facilitate data sharing, the Pilot also implemented a universal consent form that was developed collaboratively and utilized by all community partners.

Also by early 2019, Mendocino's WPC Pilot had procured but not yet implemented an electronic care coordination platform (Vertical Change). To facilitate data sharing until this platform could be implemented, all participating community partners utilized a document-sharing platform called ShareFile. Wellness coaches utilized ShareFile to access enrollment forms, universal consent forms, enrollee care plans, medication lists and other documents needed to coordinate care for enrollees. Data in ShareFile were static, but included information on enrollee medical and behavioral health service utilization.

Standardized organizational protocols to support care coordination. Mendocino's Pilot did not include standardized protocols for referral pathways, or for monitoring and follow-up of referrals. However, each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. All care coordination services were contracted out to external service providers, who were provided with financial incentives for achieving milestones or performance targets and attending collaborative care meetings. Mendocino County HHSA was reimbursed for care coordination services primarily through two per-member-per-month (PMPM) bundles, which were assigned based on enrollee acuity (high vs. low).

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Mendocino's WPC Pilot used Wellness Coaches to initiate contact with potential enrollees, and to schedule an intake meeting if the individual was interested. The majority of ongoing communication occurred in-person through field visits, but could also include telephonic communication. Wellness coaches were expected to contact enrollees on a weekly basis.

Conduct needs assessments and develop comprehensive care plans. Wellness Coaches or other agency staff completed an intake process that included a list of questions that helped identify the area of need for each of the enrollees. Comprehensive care plans were maintained in ShareFile and accessible to all key WPC partners. Once the client was enrolled, the Wellness Coach assisted in making an appointment for a biopsychosocial assessment if one had not been done in the last year, as well as performing the Vulnerability Index-Service Prioritization Decision Assistance Tool or VI-SPDAT.

Actively link patients to needed services across sectors. Mendocino's WPC wellness coaches used active referral strategies to refer their enrollees to needed services and ensure they received needed services. For example, Wellness Coaches accompanied enrollees to scheduled medical or behavioral health

appointments and assisted in enrolling them in social services and benefits.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Mendocino's WPC Pilot required multidisciplinary team members to participate in care conference meetings every three months. Wellness Coaches also participated in monthly trainings and supervisory meetings.

Suggested Citation

Lu C, Chuang E, Albertson E M., Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Mendocino County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Monterey County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Monterey County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Monterey County spearheaded its effort through Monterey County Health Department (MCHD) (primarily through its Public Health and Behavioral Health Bureaus) and worked closely with the county's Department of Social Services. An initial cadre of community partners included the Continuum of Care agency, a number of homeless services providers, and two low-income housing developers.

To identify potential enrollees, Monterey's WPC Pilot relied on high utilizer data generated by the county-owned safety-net hospital and referrals from other partnering homeless services agencies. The Pilot prioritized enrollment of homeless Medi-Cal beneficiaries with comorbidities and/or a history of high utilization of the medical system.

The overall characteristics of Monterey's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Monterey WPC Pilot Overview

Lead Entity		Monterey County Health Department (MCHD)	
5-Year Projected Enrollment		412	
Enrollment Strategy		Referrals and Direct Outreach	
Primary Target Population(s)		Homeless	
16 Partner Organizations			
4 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	9 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Monterey's WPC Pilot focused on improving blood pressure and diabetes control, substance use disorder assessments and counseling, suicide risk assessment and depression remission rates, successful long-term housing, hospital readmission rates, and discharge follow-up rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Four two-person teams primarily provided care coordination services. Each team included a public health nurse (PHN) case manager and an assistant, typically either a licensed vocational nurse (LVN) or behavioral health aide. The PHN was responsible for prioritizing enrollee needs and delegated remaining care coordination activities to his/her assistant. The Pilot focused on hiring staff with a public health background and experience working with impoverished individuals with chronic diseases. Average PHN caseload was approximately 40 enrollees.

The PHN and assistant teams had access to a multidisciplinary team of care coordination support staff, including social workers, alcohol and other drug treatment providers, mental health clinicians, benefit specialists, and housing specialists. As enrollee needs required, the PHN and assistant teams would work with these care coordination support staff to ensure enrollees received specialized care.

Data sharing capabilities to support care coordination. By early 2019, Monterey's WPC Pilot had data sharing agreements executed with all key partners, including the county's managed care plan, hospitals, and social services and community partners. Monterey's WPC Pilot relied on a two-step consent process in lieu of a single universal consent form. The first consent provided WPC with permission to access data needed to confirm an individual's eligibility for WPC. The second consent for data sharing was required to officially enroll individuals into the program and grant WPC permission to share the enrollee's medical, behavioral health, substance use, and HIV/AIDS status with specific entities.

Care coordinators reported using an existing electronic health record, Epic, to create and access enrollee care plans, track care coordination activities, and access other enrollee health data. Behavioral health data and service utilization were sourced from Avatar. Care coordinators were able to access Epic while in the field, and were able to access Monterey County Clinic services data, but were not able to access real-time updates regarding external service utilization (e.g., emergency department visits).

WPC partners could not access the care plan or other enrollee data unless they already had Epic, and in early 2019, Monterey's WPC Pilot was in the process of procuring new case management software to better support WPC activities.

Standardized organizational protocols to support care coordination. Monterey's WPC Pilot had protocols in place for referring enrollees to needed services, including for common conditions such as diabetes, hypertension, and depression. Given that the Pilot utilized PHNs as their primary care coordinators and the PHNs often had experience in providing home-based care, standard protocols for monitoring and follow-up were in place prior to implementation of WPC.

Financial incentives to promote cross-sector care coordination. Care coordination services were provided by MCHD and through contracted service providers. Care coordination services provided by the PHN and assistant teams were funded primarily through a single per-member-per-month (PMPM) bundle. Additional care coordination services, include but are not limited to a sobering center, housing placement services, tenancy support, mobile crisis team, and a homeless learning and wellness center, were funded as fee-for-service. To encourage care coordination services through their contracted providers, Monterey provided incentive payments for ensuring enrollees had medical and behavioral follow-up appointments within 30 days of hospital discharge.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Upon receiving a referral, PHNs and their assistants attempted to contact potential enrollees either by telephone or through field-based outreach. Completion of the two-step consent process was required for enrollment. Following enrollment, ongoing communication between care coordinators and enrollees occurred mostly in-person and several times a month until an enrollee's condition was more stable.

Conduct needs assessments and develop comprehensive care plans. All enrollees received a comprehensive needs assessment that included assessment of vulnerability, social needs, and the Patient Health Questionnaire-9 or PHQ-9 for depression. Enrollee needs were assessed at least once a year and more often as needed, and results were used to inform development of comprehensive care plans, which were stored in Epic. WPC external partners did not have access to Epic.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to ensure enrollees received needed services. For example, care coordinators worked closely with other county staff to arrange medical and behavioral health services for enrollees. For social services, enrollees were linked to staff in the Department of Social Services. Care coordinators reported frequently accompanying enrollees to appointments and/or arranging for transportation to help ensure enrollees attended needed appointments.

Promote accountability within care coordination team. WPC care coordinators met monthly with counterparts from social services, housing, and behavioral health for a confidential case conference. The Pilot also held monthly meetings to discuss general communication, coordination, and sustainability topics. To facilitate communication, care teams reported use of group text messaging to keep each other apprised of changes to their daily schedule and tasks.

Suggested Citation

O'Masta B, Chuang E, Albertson E M., Lu C, Haley LA, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Monterey County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Napa County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Napa County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Napa County Health and Human Services Agency (HHSA) worked most closely with two county agencies (Mental Health Department and the local hospital), one managed care plan, and two community partners.

Eligible enrollees were identified using referrals from various organizations, including Napa's emergency services and housing services providers that were not part of the lead entity's organization (e.g., Emergency Medical Services, Police and Fire Departments). Individuals usually remain enrolled until they are housed, in stable condition, and no longer need WPC services.

The overall characteristics of Napa's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Napa WPC Pilot Overview

Lead Entity		Napa County Health and Human Services Agency (HHSA)	
5-Year Projected Enrollment		800	
Enrollment Strategy		Referrals	
Primary Target Population(s)		Homeless, At-Risk-Of-Homelessness	
11 Partner Organizations			
2 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	6 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Napa's WPC Pilot focused on reducing homelessness, reducing avoidable hospitalizations, and reducing emergency department use by improving overall beneficiary health, increasing suicide risk assessment, increasing access to permanent housing, and implementing strategies to reduce 30-day all cause readmissions.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a team that varied based on enrollee housing status. Enrollees not yet in the coordinated entry system received mobile engagement services from an outreach team comprised of individuals with experience in social work or the lived experience of homelessness. Enrollees waiting for housing while in the coordinated entry system received housing navigation services, and enrollees that were already housed received tenancy support services from case managers with a variety of backgrounds (e.g., nursing, mental health). The average caseload of care coordinators was 40 enrollees.

Data sharing capabilities to support care coordination. By early 2019, Napa's WPC Pilot was finalizing a data sharing agreement with the local hospital but had executed agreements with all other partners. To facilitate data sharing, Napa implemented a universal consent form among all WPC partner organizations.

As of 2019, the Pilot had not yet implemented an electronic care coordination platform, but was able to use a data warehouse and the Homeless Management Information System (HMIS) to store and collect data on enrollees. Enrollee care plans were also shared with partners via HMIS. However, because not all care coordinators were able to access HMIS and the data warehouse, the Pilot also relied on non-electronic methods of data sharing. Subsequently, planned implementation of a care coordination platform was intended to facilitate electronic information sharing, remote access to data, and real-time notifications of enrollee service utilization.

Standardized organizational protocols to support care coordination. Napa's WPC Pilot included standardized protocols for referrals, monitoring, and follow-up during the early part of 2019. To accomplish this, they developed memorandum of understandings with medical, behavioral health and social services partners to clearly define protocols for referrals, monitoring, and follow-up.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided through contracts with external service providers, including a housing organization and the local hospital. HHSA mainly received funding to provide care coordination services through three per-member-per-month (PMPM) bundles: mobile engagement, coordinated entry services, and tenancy care. The mobile engagement service bundle was mainly for enrollees that were homeless and had yet to be entered into the coordinated entry system. The coordinated entry services bundle was for those individuals that had been entered into the coordinated entry system and included housing navigation to assist the enrollees in becoming housing-ready. The tenancy care bundle was for individuals that were successfully housed. Incentive payments were used to encourage care coordination infrastructure and services, including funds for community outreach and migration of key information into the HMIS.

In the last years of the Pilot, Napa planned to have enhanced care coordination services for the 40 highest acuity WPC enrollees through a contract with the hospital CARE (Case Management; Advocacy; Resource & Referral; and Education) Network.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Napa's WPC Pilot used homeless outreach teams located in one of the contracted services providers and in the Napa Police Department to initiate contact with eligible enrollees. These outreach teams worked to identify and engage individuals experiencing both unsheltered homelessness (i.e., encampments) and sheltered homelessness, performed initial intake assessments, enrolled individuals, and entered the enrollee into the coordinated entry system. The homeless outreach teams had vehicles to assist them with this work. Ongoing communication with

enrollees by the care coordination teams occurred primarily in-person and averaged two to three times per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Napa's WPC Pilot used a variety of need assessment tools to determine enrollees' needs, including the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to determine enrollee's need for coordinated entry services. In addition, Napa used a self-sufficiency matrix at least every six months to evaluate enrollee progress in the program. The Mental Health Department performed additional assessments for individuals with mental health issues.

Care plans for WPC enrollees in Napa included a housing service plan and a housing stability plan. The care plan was a client-centered document, addressing issues such as medical and behavioral health needs, as well as documentation needed by the enrollee to secure housing. The housing stability plan addressed what the enrollee needed to maintain housing and was updated as needed for the client (anywhere from weekly to yearly). The documents were maintained in HMIS and accessible to multiple partners involved in the enrollee's care.

Actively link patients to needed services across sectors. Napa's WPC care coordinators used active referral strategies to refer their enrollees to needed services, including medical, behavioral health, and social services. For medical services, the HHSA formed agreements with the local hospital and clinics to arrange for referrals and co-located a medical provider at the day center and shelter to provide basic medical services onsite. Behavioral health and social service staff were also co-located at the day center and shelter, which allowed care coordinators to easily refer enrollees to services and ensure enrollees received needed services.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Napa's WPC Pilot required meetings and other forms of communication between partners and providers to coordinate care, in part because they did not yet have an electronic care coordination platform. The coordinated entry system held a housing meeting every other week with many of the key WPC service providers to discuss individuals with the highest needs. Additionally, each organization had weekly case management and care coordination meetings to receive updates on enrollee progress and discuss any service needs or challenges faced by the enrollees.

Suggested Citation

O'Masta B, Chuang E, Albertson E M., Lu C, Haley LA, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Napa County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Orange County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Orange County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Orange's Health Care Agency (HCA) worked most closely with three county partners (Community Resources, Behavioral Health Services, and Housing Authority), a managed care plan (CalOptima) and a range of community partners (e.g., local health clinics, medical centers and social service providers for those experiencing homelessness or mental illness).

To identify eligible enrollees, Orange's WPC Pilot developed lists of individuals that met eligibility criteria based on administrative data from the managed care plan. Additionally, the Pilot received referrals from partners, including Behavioral Health Services (BHS), a local hospital, and local shelters. Length of enrollment in the Pilot could vary from months to years depending on each individual's needs and motivation. The Pilot did not have a formal graduation process; however, enrollees graduated from the program once they no longer needed WPC services.

The overall characteristics of Orange's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Orange WPC Pilot Overview

Lead Entity			County of Orange, Health Care Agency (HCA)
5-Year Projected Enrollment			9,303
Enrollment Strategy			Administrative Data from Managed Care Plan and Referrals
Primary Target Population(s)			Severe Mental Illness and/or Substance Use Disorder, Homeless
24 Partner Organizations			
1 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	20 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Orange's WPC Pilot focused on improving diabetes control rates, and reducing

emergency department utilization, inpatient stays, and all-cause hospital readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a range of different public and private partner organizations. Staff providing care coordination services varied based on enrollees' point of entry into the program, but included social workers, mental health specialists, nurses, licensed vocational nurses and community outreach workers. Several partnering organizations hired staff with lived experience to facilitate enrollee engagement. Staff caseload also varied across organizations and by role, but typically ranged from 10-15 enrollees for BHS mental health specialists and 30-60 enrollees for hospital or local community clinic-based care coordinators.

Data sharing capabilities to support care coordination. As of November 2018, Orange had data sharing agreements in place with all key partner organizations and implemented a single universal consent form to facilitate data-sharing. Orange's WPC Pilot also developed and implemented a new care coordination platform (called WPC Connect). This platform was used by care coordinators to enroll individuals in the program; develop, store, and share care plans with WPC partners; access established contacts and services for enrollee; and send referrals to providers. Behavioral health and social service data were automatically uploaded on a daily basis. Staff could access WPC Connect using phones or tablets in the field, and received real-time notifications when enrollees accessed the emergency department.

Standardized organizational protocols to support care coordination. Orange's WPC Pilot used standardized protocols for referral pathways and referral tracking and follow-up. For example, all WPC providers also used the WPC Behavioral Health Outreach & Engagement team to assess WPC enrollee needs and make behavioral health referrals. All care coordinators were required to submit monthly referral lists and were held accountable by Orange's HCA for ensuring those referrals were tracked and followed-up on.

Financial incentives to promote cross-sector care coordination. Orange's HCA contracted out all care coordination services to external service providers (e.g., county BHS, the hospital, and local clinics). The Pilot's care coordination services were financed by three per-member-per-month (PMPM) bundles: 1) homeless navigation services in the hospital and clinics; 2) supportive and linkage services at drop-in and multi-service centers; and 3) specific outreach & navigation for those with serious mental illness. Enrollees were assigned to a PMPM bundle based on their need and acuity.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Initial outreach and engagement of potential enrollees typically occurred in the field. Once enrolled, ongoing communication between enrollee and care coordination staff typically occurred in-person and/or by telephone. Staff met with each enrollee at least once a month, or more frequently depending on the enrollee's needs.

Conduct needs assessments and develop comprehensive care plans. As of early 2019, needs assessment processes were not standardized and varied across participating organizations. However, care coordinators were all required to develop a single, comprehensive care plan that was accessible to all WPC partners.

Actively link patients to needed services across sectors. Active referral strategies were described as a key component of Orange's WPC Pilot. Care coordinators were able to use the WPC Connect platform to directly refer enrollees to needed medical, behavioral health and social services. For example, when referring enrollees for medical care, care coordinators would help enrollees access or change their primary care provider, coordinate transportation

to appointments, and facilitate access to recuperative care when needed.

Promote accountability within care coordination team. Each partner organization had their own accountability structure. For example, the local shelter held regular meetings with key partners (e.g., county BHS, the managed care plan, public health nurses) to discuss their enrollees and their needs. As of early 2019, care coordinators were not yet accountable for following enrollees across organizational boundaries even though each organization providing care coordination services had their own systems in place to support these activities. However, the pilot noted as part of their oversight that some of the more challenging WPC clients needed more care coordination. and Orange's WPC Pilot was already in the process of developing a new core care coordinator position and concept that would be responsible for serving as the primary point of contact for the length of an enrollee's involvement with the WPC program.

Suggested Citation

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Placer County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Placer County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Placer County Health and Human Services (HHS) worked most closely with other County programs, law enforcement, two managed care plans and community-based organizations.

Eligible enrollees were identified primarily through referrals from partner organizations (e.g., hospitals, managed care plans, probation and law enforcement, and other community partners) and from community outreach to identify individuals who were homeless and/or on probation who might be eligible for WPC services.

The overall characteristics of Placer's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Placer WPC Pilot Overview

Lead Entity	Placer County Health and Human Services (HHS)
5-Year Projected Enrollment	450
Enrollment Strategy	Referrals
Primary Target Population(s)	High Utilizers, Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness, Justice Involved

20 Partner Organizations			
2 County Health and Mental Health	3 County Housing, Justice, or Social Services	2 Managed Care Plans	13 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Placer's WPC Pilot focused on increasing housing for the homeless, reducing hospital readmission rates, improving health after medical respite, providing suicide risk assessments, and improving depression remission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a multidisciplinary team with a

range of experience. Enrollees were assigned to a primary care coordinator. This care coordinator could be an individual with lived experience similar to that of the enrollee or an individual with master's level expertise in an area of identified need. Staff were responsible for providing not only care coordination but also case management. Care coordinators were supported by nurses, clinicians, and housing specialists. Average care coordinator caseload was approximately 15 enrollees.

Data sharing capabilities to support care coordination. By 2019, HHS executed data sharing agreements with some but not all partners. The Pilot used multiple different release-of-information forms to gather consent from enrollees for data sharing.

Care coordinators used two electronic databases. An electronic health record (Avatar) was used to manage enrollee health, behavioral health, and social service data. An electronic system called PreManage was used to track care coordination activities, including the care plan, and provide care coordinators with real-time notifications when enrollees received hospital or emergency department services. Some partners directly accessed information in PreManage while others contacted care coordinators for relevant information. As of early 2019, Placer started moving all tracking activities to Avatar only, but still used PreManage to receive real-time notifications. To help promote a person-centered approach to enrollee engagement, care coordinators were provided with cell phones and laptops that they could take into the field.

Standardized organizational protocols to support care coordination. Placer's WPC Pilot included standardized referral protocols, but did not include standardized protocols for monitoring and following-up on the status of these referrals. Each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided directly by HHS, rather than through contracts with external service providers. HHS was reimbursed for WPC care coordination services primarily through a per-member-per-month (PMPM) bundle for comprehensive complex care coordination. The Pilot's original plan to provide partners with incentive payments for holding appointment times specifically for WPC enrollees were not found to be necessary due to the effective coordination between WPC and its partners. The Pilot redirected these incentive funds to the provision of services.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Placer's WPC Pilot mainly used in-person communication with enrollees, though enrollees could also be reached by telephone and text message. Care coordinators typically communicated with enrollees at least once per week, but at a minimum once per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, and typically repeated assessments once per year. Validated instruments used as part of the assessment included the Patient Health Questionnaire-9 or PHQ-9 screener for depression and the Columbia Suicide Assessment form. Needs assessments directly informed development of a comprehensive care plan, which were made accessible to partners through the PreManage system.

Actively link patients to needed services across sectors. Placer's WPC care coordinators used active referral strategies to refer their enrollees to needed services. Care coordinators regularly referred enrollees to primary care, behavioral health services, and social services, utilizing a "whatever it takes" approach similar to the principles of Assertive Community Treatment.

Promote accountability within care coordination team. In order to ensure

accountability within the care coordination team, Placer's WPC Pilot required care coordinators to meet in-person on a weekly or bi-weekly basis. Care coordinators also communicated by email and phone. Supervisors met weekly with care coordinators to provide support around crisis management and case consultation.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Placer County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Riverside County

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Riverside County's WPC Pilot using this framework from implementation to March 2019.

Background

Riverside University Health System (RUHS) is a large health system that includes the Riverside Medical Center, a Behavioral Health Department, a Public Health Department, federally qualified health centers, and primary and specialty care clinics.

To implement WPC, RUHS worked most closely with the Riverside County Probation Department, as well as the County Sheriff's Department, County Social Services, managed care plans, and its community-based service providers.

The overall aim of Riverside's Pilot was to support individuals during the transition from correctional institutions to the community. Thus, eligible enrollees were primarily identified by registered nurses (RNs) who were located on-site at probation offices and screened probationers to evaluate their health, behavioral health, substance use, housing and social needs. These nurses then connected eligible individuals to care managers. Staff also engaged in targeted outreach in the community, for example at probation resource fairs.

The overall characteristics of Riverside's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Riverside WPC Pilot Overview

Lead Entity		Riverside University Health System (RUHS)	
5-Year Projected Enrollment		10,018	
Enrollment Strategy		Screening at Probation	
Primary Target Population(s)		Justice-Involved	
15 Partner Organizations			
4 County Health and Mental Health	4 County Housing, Justice, or Social Services	2 Managed Care Plans	5 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care and better health, Riverside's WPC Pilot focused on reduction of re-incarceration, reduction of inappropriate ED use, improving blood pressure

and diabetes control, overall beneficiary health, increasing suicide risk assessment and depression remission rates, and increasing individuals successfully housed.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. To identify enrollees for care coordination services, the Pilot placed eight nurses at nine probation offices. Once enrolled in the program, enrollees were linked to a care manager to receive care coordination services. The care team also included specialists in mental health, alcohol and drug dependence, housing and benefit eligibility. Care managers accessed these specialists as enrollees' needs required. In addition, peer support specialists with lived experience similar to the enrolled population were available to encourage enrollee engagement. Average caseload for RN care managers was 70 to 100 enrollees.

Data sharing capabilities to support care coordination. By 2019, RUHS had executed data sharing agreements with all partners. The Pilot used a segmented universal consent that allowed data sharing across partners. However, care plans were not accessible across all partner organizations.

The Pilot used multiple electronic systems to capture information about enrollees. Nurse care managers mainly used Epic, an electronic health record, for daily care coordination activities. Partners providing care in other departments had read-only access to the Epic database. Care coordinators also had read-only access to partner agency databases containing housing and behavioral health records. In order to facilitate care coordination in the field, care coordination staff had remote access to data.

Standardized organizational protocols to support care coordination. The Pilot created standardized protocols for referring enrollees to services and monitoring and following up on the status of referrals. All referrals were tracked for compliance and outcomes. Ongoing information on referral compliance was provided from the referral agencies (e.g., Behavioral Health Department) to the WPC team. When a client did not follow through with a referral, the RN care manager reached out to the enrollee to assist with barriers. The RN care manager made up to four failed contacts when an enrollee who had not attended their referred appointments.

Financial incentives to promote cross-sector care coordination. RN care managers and their support team were hired by RUHS and provided all care coordination. The Pilot did not contract out care coordination services. Reimbursement of services was through two per-member-per-month (PMPM) bundles for care management and housing support.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Riverside's WPC Pilot used in-person contact at probation offices to initiate outreach and screen eligible enrollees for needs. Ongoing communication occurred primarily by phone, though in-person meetings and other modes such as letters were also used. As appropriate, RN care managers worked with enrollees' probation officers to determine the best way to communicate, which could include reaching enrollees through their friends or families. Care managers were expected to contact enrollees at least once per month.

Conduct needs assessments and develop comprehensive care plans. Screening nurses performed a formal needs assessment at intake that included a homeless screening tool, a substance use disorder questionnaire, a behavioral health questionnaire, and a WPC-specific assessment to assess use of prescription medications, medical conditions, health insurance coverage, food stamps, and other needs. Nurse care managers repeated this core WPC assessment every six months. Assessment results were used to guide warm hand-offs and connections to service providers. Assessment results and care plans were maintained in Epic.

Actively link patients to needed services across sectors. WPC screening RNs used active

referral strategies to refer their enrollees to needed services. For example, screening RNs were actively involved in helping enrollees make initial medical, behavioral health, and social services appointments and as appropriate, used warm hand-offs to connect enrollees to other providers. RN care managers followed-up on appointments made by the screening nurse at intake. Other members of the care team also used active referral strategies. For example, housing outreach workers drove enrollees to appointments.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Riverside's Pilot required regular "huddles" or brief meetings between nurse screeners and staff at the probation department. Members of the care team also communicated about enrollees and care plan objectives using email. There were monthly meetings in both the eastern and western regions of the county that included behavioral health staff, detention staff, RN care managers, housing representatives, law enforcement, Medi-Cal managed care providers, substance use providers, and probation officers.

Suggested Citation

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: City of Sacramento

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under the City of Sacramento's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, the City of Sacramento worked closely with community-based service providers, including outreach partners, community clinics, and housing organizations, as well as multiple managed care plans and hospital systems. Providers were organized into four service lines based on the primary type of service provided: eligibility and enrollment, outreach and referrals, housing, and "hub" clinical care coordination. Each enrollee was assigned to a Pathways Care Team comprised of an outreach provider, hub provider, and housing provider.

The Pilot aimed to support people who were homeless and who had high utilization of health care services. Eligible enrollees were identified by direct referrals from partner organizations, and through community outreach at locations such as shelters, encampments, and hospitals.

The overall characteristics of Sacramento's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Sacramento WPC Pilot Overview

Lead Entity		City of Sacramento	
5-Year Projected Enrollment		3,787	
Enrollment Strategy		Direct Referrals and Outreach	
Primary Target Population(s)		High Utilizers, Homeless	
28 Partner Organizations			
4 County Health and Mental Health	1 County Housing, Justice, or Social Services	7 Managed Care Plans	16 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, Sacramento's Pilot focused on improving self-reported health status, decreasing inpatient visits, readmissions, and emergency department visits, and increasing the percentage of homeless enrollees who received housing support services.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were

provided primarily by community health workers (CHWs). Outreach CHWs provided ongoing connection to social services and supports and typically had lived experience similar to the enrollee population. In the community clinic "hubs," clinical care coordinators supported enrollees and licensed clinical staff such as social workers and nurses who were available for more intensive case management. Housing service providers offered other specialized staff to help provide housing support. Caseloads varied by provider organization and with program enrollment; however, caseloads typically ranged from 25 to 75 for housing providers, 50 to 65 in the health care "hubs," and 60 to 70 for the outreach and referral providers.

Data sharing capabilities to support care coordination. By 2019, the City of Sacramento had executed data sharing agreements with most of its partners. To facilitate data sharing, Sacramento also implemented a universal consent form used by the WPC eligibility and enrollment partner organizations.

Sacramento's Pilot used Salesforce to host an online "Shared Care Plan Portal" to store and share enrollee care plans and facilitate real-time data sharing of critical enrollee information (e.g., referrals, goals, concerns, acuity level, interventions, etc.). Care coordinators were able to review service referrals in the system daily to guide their work, and accessed the platform remotely while in the field. Medical contacts were not maintained in the platform but instead stored in separate electronic medical record (EMR) systems. Care coordination staff did not receive real-time notifications of ED visits.

Standardized organizational protocols to support care coordination. Sacramento's Pilot did not include standardized protocols for referring enrollees to needed services. Each partner in Sacramento's WPC Pilot used their own internal protocol for making referrals based on enrollee needs identified in the care plan. The data system allowed for referral tracking and follow-up, and each provider used their own internal protocol for monitoring receipt of services.

Financial incentives to promote cross-sector care coordination. The City of Sacramento was reimbursed for WPC care coordination services primarily through three per-member-per-month (PMPM) bundles that paid a set amount per enrollee. The PMPM bundles were for high-intensity care coordination, low-intensity care coordination, and housing support.

The City of Sacramento contracted out all care coordination services to external providers rather than providing them directly. Contracts outlined the Pilot's expectations for care coordination (e.g., regarding minimum frequency of engagement with enrollees). In addition, incentive payments facilitated adoption and support of WPC policies and procedures and participation in data sharing and reporting activities.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Sacramento's Pilot used in-person communication to initiate contact with eligible enrollees. For example, staff visited locations such as shelters and campsites. Care coordinators were expected to engage and follow up with enrollees multiple times per month. The City of Sacramento required this frequency of contact in its contracts, and periodically conducted reviews to ensure compliance.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, and an additional assessment at 90 days to determine enrollee acuity level and progress towards graduation. An additional assessment was required for enrollees to graduate. Assessments informed the development of comprehensive care plans. These comprehensive care plans were updated and shared in the Shared Care Plan Portal.

Actively link patients to needed services across sectors. Care coordinators used active

referral strategies to refer their enrollees to needed services. For example, outreach CHWs helped enrollees apply for social services, schedule appointments, arrange transportation for appointments, and retrieve documentation required for services. "Hub" care coordinators supported and monitored referrals to primary care, specialty care, and behavioral health services. Housing care coordinators supported and monitored referrals into various housing programs (e.g., Housing and Urban Development), Continuum of Care housing programs, and the Housing Choice Voucher program).

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Sacramento's Pilot required weekly huddles to share data and promote learning. Care team staff also communicated with each other by email, and tracked contacts with enrollees in the Shared Care Plan Portal. Staff held case conferences with external providers and partners as needed.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: City of Sacramento.* Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: San Benito County

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under San Benito County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, San Benito County Health and Human Services Agency (HHSA) worked most closely with the local hospital and their four clinics, and the homeless shelter due to the Pilot's goal of improving health outcomes for people who were homeless.

Eligible enrollees were primarily identified through referrals. Initially, eligible enrollees were also identified through active outreach and engagement efforts.

The overall characteristics of San Benito's Pilot are displayed in Exhibit 1. San Benito's WPC Pilot was a member of the Small County Whole Person Care Collaborative (SCWPCC), along with Mariposa.[1] Although counties in the collaborative shared some infrastructure and processes, each county's program was distinct.

Exhibit 1: San Benito WPC Pilot Overview

Lead Entity		San Benito County Health and Human Services Agency	
5-Year Projected Enrollment		114	
Enrollment Strategy		Referrals and Active Outreach	
Primary Target Population(s)		High Utilizers, Homeless, At-Risk-Of-Homelessness	
11 Partner Organizations			
3 County Health and Mental Health	3 County Housing, Justice, or Social Services	1 Managed Care Plan	4 Community Partners[2]

Notes: [2] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, San Benito's WPC Pilot focused on improving suicide risk assessment rates, housing services, implementing a uniform housing assessment tool, and reducing hospital readmission rates.

[1] Plumas County was initially a member of the collaborative, and subsequently ended their participation in WPC in September 2018.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by social workers who served as the primary point of contact for enrollees. The focus on social work was partly due to limited availability of public health nurses in the county. In 2019, the Pilot considered hiring peer staff with similar lived experience as WPC enrollees in order to encourage enrollee engagement. Average care coordinator caseload was 8 to 10 enrollees.

Data sharing capabilities to support care coordination. By 2018, HHSA executed data sharing agreements with some partners. To facilitate data sharing, San Benito implemented a universal consent form among all WPC partner organizations.

San Benito's Pilot used a single electronic system, called eBHS, to store and share enrollee data. Care coordinators documented all care coordination activities in eBHS, including referrals, engagement activities, utilization, assessments, and the care coordination plan. To help promote a person-centered approach to enrollee engagement, care coordinators were able to access eBHS in the field. The Pilot's ultimate goal was to use eBHS for real-time communication, although in 2019 they were still in the process of building out the functionality of the system. Information in eBHS could be shared with the managed care plan and county staff, but not with other partner organizations.

Standardized organizational protocols to support care coordination. San Benito's Pilot included standardized referral protocols that were updated every six months. The Pilot also included standardized protocols for tracking and monitoring referrals in the eBHS data system.

Financial incentives to promote cross-sector care coordination. All care coordination services were provided directly by San Benito HHSA, and reimbursed primarily through a per-member-per-month (PMPM) bundle for comprehensive care coordination. A second bundle also funded housing support services and these services were also provided by HHSA staff.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. San Benito's Pilot mainly used in-person communication with enrollees, though enrollees could also be reached by telephone. Care coordinators contacted enrollees at least once a week, and sometimes more often, depending on enrollee needs.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. The Vulnerability Index - Service Prioritization Decision Assistance Tool (VISPDAT) was conducted once per year. The PHQ-9 screening for depression was conducted at intake and at least every six months, or more often if an enrollee had a high score. Additionally, depending on their response to the PHQ-9, some enrollees completed the Columbia Suicide Severity Rating Scale. Staff also administered a strengths assessment, and updated it as enrollees identified new strengths and goals. Assessments informed a single, person-centered care plan that was stored and access across partners on eBHS.

Actively link patients to needed services across sectors. San Benito's WPC care coordinators used active referral strategies to refer their enrollees to needed services. For example, care coordinators helped enrollees identify a primary care provider (PCP), and accompanied enrollees to visits when needed. Care coordinators also helped enrollees apply for financial support and other benefits programs such as Calfresh and Supplemental Security Income, and provided warm hand-offs to other WPC programs if enrollees moved to a different county.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, San Benito's Pilot required care coordinators to participate in regular, weekly meetings. At these

weekly meetings, staff from the hospital, homeless shelter, and managed care plan were invited to attend. Care coordinators were required to track activities in eBHS as a form of accountability.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: San Benito County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: San Bernardino County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program, implemented under the Section 1115 Medicaid Waiver, was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under San Bernardino County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Arrowhead Regional Medical Center (ARMC) worked most closely with two managed care plans, two county agencies (Department of Behavioral Health (DBH) and Human Services Department), and two community partners (Information Services and Sheriff's Department).

San Bernardino's WPC Pilot identified eligible enrollees using a scoring algorithm based on administrative data from multiple partners (ARMC, County Public Health and Behavioral Health, and the local managed care plans) and intended to identify chronic conditions and high utilization of inpatient, emergency department, Psychiatric, and/or substance use disorder (SUD) treatment. Enrollees could "graduate" from the WPC program upon completing care plan goals and participated in a formal graduation process that included receipt of a letter of recognition.

The overall characteristics of San Bernardino's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: San Bernardino WPC Pilot Overview

<table>
<tr><td>Lead Entity</td><td colspan="3">Arrowhead Regional Medical Center (ARMC)</td></tr>
<tr><td>5-Year Projected Enrollment</td><td colspan="3">2,120</td></tr>
<tr><td>Enrollment Strategy</td><td colspan="3">Identified via administrative data (medical record, DBH)</td></tr>
<tr><td>Primary Target Population(s)</td><td colspan="3">High Utilizers</td></tr>
<tr><td colspan="4">19 Partner Organizations</td></tr>
<tr><td>2 County Health and Mental Health</td><td>2 County Housing, Justice, or Social Services</td><td>2 Managed Care Plans</td><td>13 Community Partners[1]</td></tr>
</table>

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and health, San Bernardino focused on increasing hypertension and diabetes control rates, improving self-reported health status, increasing

depression remission and suicide risk assessment rates, improving patient activation scores, and reducing hospital readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by ten care coordination teams, each consisting of a patient navigator supported by three specialists (an alcohol and drug counselor, a nurse, and a social worker). Patient navigators typically had experience providing care coordination and sometimes had lived experience similar to that of WPC enrollees, while specialists were selected specifically for their relevant clinical expertise. Additional staff included a WPC manager, utilization technicians, office assistants, and a business systems analyst, who provided additional back-office support to all ten teams. To achieve WPC enrollment goals, each care coordination team aimed to have a caseload of 50 enrollees.

Data sharing capabilities to support care coordination. To develop and implement their scoring algorithm, San Bernardino's Pilot ensured that data sharing agreements were in place with all key partners. The Pilot did not create a universal enrollee consent form, but instead required enrollees to complete separate release of information forms for WPC (included all managed care plans), the Transitional Assistance Department, and the Behavioral Health Agency.

WPC care teams used a population management platform (Forward Health) to access lists of potential enrollees, develop and store care plans, store notes on enrollees' care needs and services, and access enrollee medical and behavioral health data. Only WPC team members had access to this platform. The platform allowed remote access, which care coordinators accessed through county-provided smart phones and tables. The platform did not provide real-time notifications of enrollee service utilization.

Standardized organizational protocols to support care coordination. San Bernardino's Pilot did not develop standardized protocols for referral pathways, but did develop protocols for referral monitoring and follow-up. Utilization technicians assisted WPC teams in arranging appointments and following up on referrals. Communication between team members and utilization technicians occurred through phone calls, emails, and texts, as well as standardized to-do lists in the care coordination platform.

Financial incentives to promote cross-sector care coordination. San Bernardino's WPC Pilot did not contract out care coordination services. Their care coordination services were funded through a per-member-per-month (PMPM) care coordination bundle and fee-for-service field-based outreach.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Patient navigators were responsible for initial outreach to prospective enrollees. Typically, patient navigators first attempted to call potential enrollees to arrange a home visit, and if unsuccessful, would then attempt in-person contact without an appointment. Ongoing, in-person contact with enrollees was required after enrollment in the program, with care coordination teams expected to see enrollees in-person at least once per month. In addition, they typically contacted enrollees multiple times per month by telephone, e-mail, or text.

Conduct needs assessments and develop comprehensive care plans. Patient navigators were responsible for conducting a comprehensive assessment upon initial enrollment, including validated instruments such as the Patient Activation Measure (PAM) and the PHQ-9 for depression. PAM scores were used to measure enrollees' ability to manage their own care and readiness to graduate from WPC, and was therefore measured every three months. The PHQ-9 was performed at least once per year and always at enrollment and disenrollment or graduation. Based on needs identified, patient navigators referred enrollees to appropriate specialists on the WPC team (e.g.,

nurse, alcohol and drug counselor, and/or social worker) who were then responsible for developing a care plan in his/her area of expertise to share with the overall team.

Actively link patients to needed services across sectors. Care coordination teams were purposively designed to include staff with relevant expertise in medical, behavioral health, and social services so that enrollees could be referred "within team." Team members actively worked with enrollees by meeting them at their homes, in homeless encampments, or anywhere else in the community, that enabled the enrollee to feel comfortable. Through these visits, care coordinators developed tailored care plans, and ensured enrollees received the services that they needed.

Promote accountability within care coordination team. San Bernardino's WPC Pilot used a unique method to ensure accountability for WPC services. Every month, each WPC team met with the WPC Manger for a WPC Accountability Review (WAR) conference. At these conferences, the team and manager discussed every enrollee, including each enrollee's status, needs, and barriers to service. The whole team was expected to be up-to-date on each client during these meetings. To prepare, the WPC teams met weekly to cover anticipated WAR conference questions so they could be prepared. As an example of how WAR conferences promoted accountability, utilization technicians were typically responsible for referral follow-up, but at the WAR conference, the entire team was expected to know the referral status of their enrollees.

Suggested Citation

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: San Diego County

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program, implemented under the Section 1115 Medicaid Waiver, was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under San Diego County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, San Diego County's Health and Human Services Agency (HHSA) worked most closely with other county agencies such as the local Sheriff's Department, community-based health and social service providers, and multiple managed care plans.

Eligible enrollees were identified by review of administrative data and by referrals from hospitals, behavioral health providers, justice partners, and housing partners in the community. The Pilot found that referrals resulted in better enrollment and engagement than identification of enrollees from administrative data. San Diego's Pilot was designed to occur in phases: a two-month outreach and engagement phase, followed by stabilization, maintenance, transition, and aftercare. Enrollees were not considered formally enrolled in the Pilot until they entered the stabilization phase. Length of enrollment varied depending on the enrollee's needs.

The overall characteristics of San Diego's WPC Pilot called "Whole Person Wellness Pilot" are displayed in Exhibit 1.

Exhibit 1: San Diego WPC Pilot Overview

Lead Entity			County of San Diego, Health and Human Services Agency (HHSA)
5-Year Projected Enrollment			800
Enrollment Strategy			Referrals from Direct Service Partners
Primary Target Population(s)			High Utilizers, Homeless, At-Risk-Of-Homelessness
19 Partner Organizations			
2 County Health and Mental Health	4 County Housing, Justice, or Social Services	7 Managed Care Plan	6 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, San Diego's WPC Pilot focused on reducing jail recidivism, improving suicide risk assessment rates, increasing receipt of

permanent housing, and improving health care utilization through reduced emergency department (ED) visits and inpatient hospitals stays and increased primary care physician visits.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by multidisciplinary Service Integration Teams (SITs). SITs consisted of staff from various backgrounds, and typically included a bachelor's level social worker, a peer support specialist, a licensed clinician, a housing navigator, and a program manager. Either a social worker or a peer support specialist served as the primary point of contact for enrollees. Due to limited availability of clinical staff, some SITs worked closely with partner clinics to access nurse expertise. There were over ten SITs spread throughout the county. Average SIT caseload varied depending on what phase of the program the enrollee was in.

During early phases of outreach and stabilization, average SIT caseloads were approximately 25 enrollees. During later phases of transition and aftercare, average SIT caseloads were approximately 45 enrollees. In 2019, High Acuity Teams were established with caseloads of around 10 enrollees.

Data sharing capabilities to support care coordination. By 2019, San Diego County's HHSA had executed data sharing agreements with all of its partners. Many of these data sharing agreements already existed prior to WPC. The Pilot used multiple different release-of-information forms to gather consent for data sharing from enrollees; however, to facilitate data sharing, the HHSA also implemented a universal consent form for use by internal county systems and the managed care plans.

All key WPC partners used the same electronic system (ConnectWellSD) to track and report on care coordination activities. Linked data available in ConnectWellSD included medical data from mental health services and health plans, social services data from affordable housing agencies, and data from probation. Care coordinators could read and write data in the ConnectWellSD system, including contacts, notes, assessments, and workflow. To help promote a person-centered care approach to enrollee engagement, care coordinators were able to access data on electronic tablets in the field. Care coordinators also received real-time notifications if enrollees visited the ED.

Standardized organizational protocols to support care coordination. San Diego's Pilot did not include standardized protocols for referring enrollees to needed services because partner agencies accepting referrals had different pathways for accessing their services. However, the Pilot did include standardized protocols for monitoring and following up on referrals. Referrals were tracked in the ConnectWellSD system, and contracts with WPC partners required that information be entered within 48 hours of any service, contact, or referral.

Financial incentives to promote cross-sector care coordination. San Diego County's HHSA was reimbursed for WPC care coordination services primarily through per-member-per-month (PMPM) bundles in addition to the fee-for-service outreach and engagement reimbursement. PMPM bundles were defined based on the enrollee's phase in the program, ranging from stabilization to transition and aftercare. These phases were defined using milestones, such as attaining housing. PMPM payments were higher for earlier phases, and lower for later phases. The HHSA contracted out all care coordination services to external service providers. Contracted partners received incentive payments for timely enrollment and creation of care plans within 30 days of enrollment.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Care coordinators primarily communicated with enrollees in-person and by telephone. Initial outreach and engagement activities lasted for approximately two months, and consisted of approximately six

to seven contacts in the field to build trust and rapport (e.g., by following up with individualized resources). Following formal enrollment in WPC, care coordinators were expected to contact enrollees at least weekly during the early phases of the program, and later on, at least once per month.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment when enrollees were ready to transition from the outreach and engagement phase to the stabilization phase. Assessments included the PHQ-9 depression screening, the Columbia Suicide Severity Rating Scale, the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), and an in-house biopsychosocial assessment that asked about housing, income, legal situation, quality of life, substance abuse, support system, and other factors. Needs assessment informed development of a comprehensive care plan maintained in ConnectWellSD and accessible to all key WPC partners.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to refer enrollees to needed services. For example, care coordinators described using a field-based model to help enrollees access walk-in clinics, establish care with a primary care physician, and access behavioral health and social services.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, San Diego's Pilot required care coordinators to participate in weekly multidisciplinary case conference meetings. The Pilot also held regular management team meetings through weekly all-staff meetings and daily huddles.

Suggested citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: San Diego County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: San Francisco County

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program, implemented under the Section 1115 Medicaid Waiver, was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under San Francisco County's WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, San Francisco Department of Public Health (SFDPH) worked most closely with other county agencies including the San Francisco Department of Homelessness and Supportive Housing, two managed care plans, and three community partners.

Eligible enrollees were identified using administrative data from an integrated multi-agency data system and classified into three groups: severe risk (homeless more than ten years and a high utilizer of emergency care), high risk (homeless more than ten years or a high utilizer of emergency care), and elevated risk (all other homeless adults). In general, WPC services were not identified to the client as components of WPC; rather, they were integrated into the comprehensive system of care in the Health Department and/or the Department of Homelessness and Supportive Housing. Length of enrollment in WPC varied depending on the enrollee's needs.

The overall characteristics of San Francisco's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: San Francisco WPC Pilot Overview

Lead Entity		San Francisco Department of Public Health (SFDPH)	
5-Year Projected Enrollment		22,600	
Enrollment Strategy		Administrative Data	
Primary Target Population(s)		Homeless	
9 Partner Organizations			
1 County Health and Mental Health	3 County Housing, Justice, or Social Services	2 Managed Care Plans	3 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, San Francisco's WPC Pilot focused on efforts to: (1) develop a universal assessment that prioritizes the most vulnerable clients for access to scarce health, social and housing services; (2) create an interagency care response

system that will wrap around those prioritized clients in a human-centered fashion; and (3) develop an interagency data sharing platform to support both of the above.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. The WPC care coordination program was built on the foundation of an existing street medicine and homeless outreach program. Care coordination services were provided by different types of staff depending on acuity of enrollee needs and how the enrollee entered the WPC program. Care coordination teams included paraprofessional health workers with lived experience similar to that of WPC enrollees, a medical director, medical and psychiatric nurses, social workers, and a psychiatrist. Average care coordinator caseload was 20 to 30 enrollees.

Data sharing capabilities to support care coordination. By 2019, SFDPH had executed data sharing agreements with some but not all partners. Data sharing agreements were being finalized with the health plans involved in the Pilot. The Pilot did not develop a WPC-specific consent form, because this was viewed as a barrier to care that was unnecessary from the perspective of privacy laws and would discourage some prospective enrollees from participating.

Core partners utilized the Coordinated Care Management System (CCMS), an integrated database of 15 disconnected health, housing, and benefits databases for people who used services of the County's Public Health and Homeless Services Departments. The CCMS contained summary pages for each individual in the system. Partners used three different electronic health record (EHR) systems to track enrollee data, and these systems linked to the integrated CCMS system. In August 2019, San Francisco's Pilot was planning to transition to the use of a new EHR (Epic). Care coordinators could read and write data in the data systems. The Pilot did not yet have real-time alerts or remote access for care coordinators, but had identified these as future goals.

Standardized organizational protocols to support care coordination. San Francisco's Pilot did not yet include standardized protocols for referring enrollees to needed services, or monitoring and following up on referrals. In 2019, the Pilot was developing an Interagency Prioritization Pathway to help prioritize services for clients with the highest need. As of July 2019, the Pilot planned to adopt the Coordinated Entry assessment tool as the WPC universal assessment tool. From a prioritized list based on the assessment, those with histories of psychoses and substance use disorders (opiate, stimulants, cocaine, and/or alcohol) and high uses of urgent/emergent services would be further prioritized for services.

Financial incentives to promote cross-sector care coordination. Many, but not all, services were provided through contracts with external service providers. SFDPH and contracted partners were reimbursed for WPC care coordination services primarily through a per-member-per-month (PMPM) care coordination bundle that paid a set amount per enrolled person for patients with high needs. Initially, another PMPM bundle funded engagement services at navigation centers and shelters, but this was subsequently converted to fee-for-service payment. In 2019, SF was approved for a High Intensity Care Team PMPM, which would fund an interagency response to San Francisco's most vulnerable adults experiencing homelessness (those with histories of psychoses and substance use disorders, ranked by utilization of urgent/emergent service).

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. San Francisco's Pilot used street and shelter-based outreach to initiate contact with eligible enrollees. Targeted outreach to have clients assessed for priority status was planned to start in September 2019. The majority of ongoing communication occurred via in-person field visits. Care coordinators were expected to contact enrollees at least weekly, except in cases when enrollees could not be found.

Conduct needs assessments and develop comprehensive care plans. Through the use of an universal assessment tool (Coordinated Entry), enrollees were prioritized and assigned a care coordinator. Care coordinators performed a formal needs assessment at intake and assured that service-specific intakes were completed. Assessments were repeated at minimum once per year, but usually quarterly or as enrollee circumstances changed. The Pilot used assessment results to develop a comprehensive interagency care plan that clearly specified who needed to be involved in care, what services were needed, barriers to accessing these services, and processes for achieving enrollee goals. One of the Pilot's goals was to increase the proportion of enrollees with a comprehensive care plan accessible by the entire team within 30 days.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to refer their enrollees to needed services, and in the case of the street medicine teams, directly provided services. Those prioritized through the Coordinated Entry assessment had active engagement plans developed, implemented, and monitored by leadership of the systems of care.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, San Francisco's Pilot required outreach teams to participate in case meetings at least once per month. Team members communicated about clients on an ongoing basis through phone calls, case meetings, and emails.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: San Francisco County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: San Joaquin County

Connie Lu, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under San Joaquin County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, San Joaquin County Health Care Services Agency (HCSA) worked most closely with four county agencies (Behavioral Health Services, Substance Abuse Services, Correctional Health Services, and San Joaquin General Hospital), two managed care plans, and four community partners.

Eligible enrollees were identified using referrals from internal and external partners and lists of eligible individuals provided by the managed care plans.

The overall characteristics of San Joaquin's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: San Joaquin WPC Pilot Overview

Lead Entity	San Joaquin County Health Care Services Agency (HCSA)
5-Year Projected Enrollment	2,255
Enrollment Strategy	Referrals and Health Plan Lists
Primary Target Population(s)	High Utilizers, Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness

14 Partner Organizations			
6 County Health and Mental Health	1 County Housing, Justice, or Social Services	2 Managed Care Plan	5 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and health, San Joaquin's Pilot focused on increasing the number of WPC enrollees included in the local health information exchange, and on improving incarceration rates, diabetes care, suicide risk assessment rates, housing services, and reducing unnecessary emergency department and inpatient utilization.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by individuals from three core teams:

Behavioral Health Services (BHS), Community Medical Centers (CMC), and Population Health. The BHS team was part of the county BHS agency and included mental health specialists and mental health outreach workers. The CMC team was based in a local community-based organization, and the Population Health team was embedded within the county hospital and included registered nurses and licensed vocational nurses. Care coordinator caseloads ranged from 15 to 150 enrollees; however, care coordinators were typically only actively engaged with 15-20 enrollees at any given time and only provided initial outreach to any remaining enrollees in their caseload.

Data sharing capabilities to support care coordination. As of early 2019, San Joaquin's HCSA had data sharing agreements in place with most key partners, except a local private hospital. The Pilot also successfully implemented a single universal consent form used by all key partners, although obtaining consent for data sharing was described as a challenge. San Joaquin's Pilot implemented a cloud-based system (Box) to allow key partners to access enrollee care plans; sharing of care plans was contingent on having signed consent forms in place and was described as time-consuming for care coordinators.

Care coordinators in San Joaquin's Pilot also reported using multiple different systems to access data, input care plans, and track care coordination activities, largely due to each organization providing care coordination services having their own internal electronic databases for use. To facilitate care coordination across organizational boundaries, care coordinators could access and update select documents in Box; however, data available in Box were limited, and care coordinators did not commonly access this system while in the field. Additionally, care coordinators did not receive real-time alerts about enrollee service utilization.

Although not yet implemented in early 2019, San Joaquin's Pilot reported future plans to implement a new system (ActMD) that would contain more comprehensive enrollee data, be accessible while in the field, and provide real-time alerts when enrollees utilized the ED.

Standardized organizational protocols to support care coordination. As of early 2019, San Joaquin's Pilot did not have standardized protocols in place for referring enrollees to services and/or for monitoring and following up on the status of these referrals. Instead, each organization providing care coordination services had their own systems in place to support these activities.

Financial incentives to promote cross-sector care coordination. San Joaquin HCSA primarily used one per-member-per-month (PMPM) bundle to fund care coordination services, although certain services were funded on a fee-for-service basis. All care coordination services were contracted out to WPC partner organizations rather than provided directly by the HCSA. San Joaquin's Pilot provided partner organizations with financial incentives to engage in desired WPC activities. Examples included incentive payments for joining and using the San Joaquin Community Health Information Exchange, and for providing patient navigation and patient advocacy (e.g., assisting a patient not fluent in English with processes needed to access care).

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Once eligible enrollees were identified and a signed consent form was in place, care coordinators would go out in the field to meet with prospective enrollees (e.g., at recuperative care sites, in shelters, and/or at the hospital). Once enrolled in WPC, ongoing communication occurred primarily in-person in the field, but also by telephone. Frequency of contact between care coordinators and enrollees varied depending on enrollees' stage of involvement in the WPC program (e.g., initial outreach, active engagement, close to graduation). However, in general, care coordinators reported making meaningful contact more than once a month, with care

coordinators attempting contact between two and five times per week.

Conduct needs assessments and develop comprehensive care plans. San Joaquin's Pilot did not standardize needs assessment protocols or care plans, but instead allowed each organization providing care coordination to use their own tools to evaluate enrollee needs. For example, BHS teams administered a suicide risk assessment to all of their enrollees while the CMC teams regularly used the PHQ (Patient Health Questionnaire)-9. Each participating organization also used their own established care plan templates, and uploaded to Box for sharing with other partnering organizations when enrollees provided consent.

Actively link patients to needed services across sectors. The Pilot's goal was to develop infrastructure through WPC that would allow for active referral of enrollees to needed medical, behavioral health, and social services. Care coordinators were provided with contact information for a wide range of service providers to help facilitate warm hand-offs for enrollees.

Promote accountability within care coordination team. Care coordinators typically communicated with one another through email, Box, phone calls, and secure text messaging (Qlik). The Pilot did not require care coordinators to participate in regular, cross-disciplinary case conferencing meetings. However, senior and mid-level staff in relevant WPC partner organizations did participate in regular, quarterly meetings to discuss the Pilot, and identify strategies for improving care coordination processes.

Suggested Citation

Lu C, Chuang E, Albertson E M., Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: San Joaquin County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

October 2019

Care Coordination in California's Whole Person Care Pilot Program: San Mateo County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under San Mateo County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, San Mateo County Health System (SMCHS) worked closely with their managed care plan (Health Plan of San Mateo) and a number of community partners to expand existing programs and create a new program, Bridges to Wellness (BTW), for improving integration of primary care and behavioral health services.

Eligible enrollees that were high utilizers and those with chronic conditions were identified using administrative data, in addition to internal and external referrals. Length of time in the WPC Pilot varied based on each enrollee's progress in achieving agreed-upon goals. Graduation from the Pilot was determined after a clinical assessment of the client's stability and progress, followed by a warm handoff to an identified care team, often a behavioral health program or primary care.

The overall characteristics of San Mateo's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: San Mateo WPC Pilot Overview

Lead Entity		San Mateo County Health System (SMCHS)	
5-Year Projected Enrollment		4,141	
Enrollment Strategy		Administrative Data and Referrals	
Primary Target Population(s)		High Utilizers	
7 Partner Organizations			
0 County Health and Mental Health[1]	2 County Housing, Justice, or Social Services	1 Managed Care Plan	4 Community Partners[2]

Notes: [1] The lead entity performs one or more of these functions. [2] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and health, San Mateo focused on improving diabetes control, reducing emergency department visits, increasing suicide risk assessment rates, increasing successful housing, and reducing readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Staffing in San Mateo's Pilot varied by program and by the organization or health division responsible for delivering the service. Generally, the Pilot took the approach of supporting care coordination across divisions so that enrollees experienced less fragmented care. For example, the Pilot added four social workers in ambulatory care clinics to coordinate care for enrollees. In another program, an RN discharge coordinator for jailed enrollees was responsible for coordinating care for all WPC enrollees transitioning back into the community. These enrollees then were handed off to a care navigator. In the Integrated Medical Assisted Treatment Program (IMAT), Behavioral Health and Recovery Services (BHRS) alcohol and drug services had around eight case managers providing care coordination services, each with a caseload of approximately 30 enrollees.

Finally, BTW care coordination services targeted the highest-risk utilizers and were provided by 15 care navigators supported by two social workers, a nurse practitioner, a triage nurse, and a part-time medical director. The care navigators, who had lived experience similar to that of enrollees, and functioned in a community health worker role, were the main contact for WPC enrollees. Care navigators in the BTW program had a caseload of 12 enrollees and, as a result, could provide extremely intensive services.

Data sharing capabilities to support care coordination. In San Mateo, most WPC partners were internal to the health department (e.g., divisions within SMCHS). However, SMCHS did develop data sharing agreements with nearly all external partners except the Human Services Agency. As of 2019, the Pilot did not have a universal consent form. The Pilot also did not have a standardized, comprehensive care plan shared across partners and/or teams.

San Mateo's Pilot used multiple systems to support daily care coordination activities, including the local health information exchange (HIE) and electronic health record (EHR), but aimed to have a single system in place by 2020-2021. Care coordination teams could not input data into the HIE, but could access data on health, behavioral health and social determinants of health data, and also received real-time notifications when enrollees utilized the emergency department. Some but not all care coordination teams could access the EHR while in the field.

Standardized organizational protocols to support care coordination. San Mateo's Pilot did not develop standardized protocols for referral pathways and referral monitoring and tracking. While referrals pathways were used by some care coordination teams, they were not standardized across the Pilot. Each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. Care coordination services were a mix of in-house and contracted service providers. In-house care coordination services were primarily funded through two per-member-per-month (PMPM) bundles: BTW and BHRS. Assignment to the BTW and BHRS bundles was not based on enrollee acuity but instead based on point of entry into the system. For care coordination services provided through contracts with external providers, SMCHS used incentive payments to encourage attendance at complex case conferences and participation in staff training on the use of the HIE.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Outreach and engagement in San Mateo's Pilot occurred in-person and in the field, where care navigators spent most of their time. Once referred for WPC services, care navigators had up to six months to engage and obtain enrollee consent. Once enrolled, care navigators typically continued to meet with enrollees in-person. While care navigators were required to make contact once per month, staff commonly reported multiple contacts per day or week.

Conduct needs assessments and develop comprehensive care plans. In San Mateo's Pilot, needs assessment processes varied across WPC programs. For most enrollees, a needs assessment was performed after the Pilot received signed consents. Assessments focused on mental health, alcohol and drug treatment, housing, and medical needs and were repeated annually. Because San Mateo's Pilot did not have a standardized care plan, care navigators reported reviewing several different care plans across different systems.

Actively link patients to needed services across sectors. Care coordination teams all utilized active referral strategies to ensure their enrollees received needed medical, behavioral health, and social services. For example, care navigators met with their enrollees in the field and would coordinate transportation for them to their medical appointments. All care coordination teams also reported assisting enrollees in applying for and maintaining needed benefits.

Promote accountability within care coordination team. Most care navigators were required to complete a daily progress note each time they contacted an enrollee. Across teams, care navigators reported frequently calling and emailing other teams to discuss enrollee needs; however, these activities were informal and the Pilot did not require participation in regular, in-person across team meetings. Within teams, regular weekly, in-person meetings were held. Additionally, progress notes and treatment plans were available to all team members and supervisors to increase accountability within teams.

Suggested Citation

O'Masta B, Chuang E, Albertson E M., Lu C, Haley LA, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: San Mateo County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Santa Clara County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Elaine M. Albertson, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Santa Clara County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, the County of Santa Clara Health System (CSCHS) worked most closely with six county agencies (Public Health, Information Systems, Reentry Services, Behavioral Health, Supportive Housing, and Social Services), one public medical center, one Medi-Cal managed care plan, and eleven community partners.

Santa Clara's Pilot utilized an opt-in enrollment process and identified eligible enrollees by referral and through lists provided by the Medi-Cal managed care plans, in which administrative data were used to assign potential enrollees a High Utilizer of Multiple Systems (HUMS) score. The length of time that enrollees stayed in the program varied based on need. The Pilot launched a formal graduation process in 2018.

The overall characteristics of Santa Clara's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Santa Clara WPC Pilot Overview

<table>
<tr><td colspan="2">Lead Entity</td><td colspan="2">County of Santa Clara Health System (CSCHS)[1]</td></tr>
<tr><td colspan="2">5-Year Projected Enrollment</td><td colspan="2">9,000</td></tr>
<tr><td colspan="2">Enrollment Strategy</td><td colspan="2">Referrals and Administrative Lists</td></tr>
<tr><td colspan="2">Primary Target Population(s)</td><td colspan="2">High Utilizers</td></tr>
<tr><td colspan="4">35 Partner Organizations</td></tr>
<tr><td>7 County Health and Mental Health</td><td>5 County Housing, Justice, or Social Services</td><td>2 Managed Care Plans</td><td>21 Community Partners[2]</td></tr>
</table>

Notes: [1] Previously the Santa Clara Valley Health and Hospital System (SCVHHS) [2] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, Santa Clara's WPC Pilot focused on ensuring needs assessments were completed within 60 days of enrollment, increasing supportive housing, improving depression remission rates and suicide risk assessment rates, and reducing all-cause readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination teams varied based on enrollee needs and the specific organization providing care coordination services. Community health clinics employed Community Health Workers (CHWs), Licensed Clinical Social Workers (LCSWs), and nurses (RN and LVN), while the CSCHS clinics initially employed nurses and LCSWs and later planned to hire CHWs. Many CHWs had lived experience similar to WPC enrollees to help with engagement. Care coordinators did not have a set caseload, but those providing short-term care management and assisting with nursing home transitions typically worked with between 20-50 enrollees at a time, while those providing more intensive mid- and long-term care management services had caseloads of between 10-20 enrollees.

Data sharing capabilities to support care coordination. Santa Clara's WPC Pilot developed a Trust Community (TC) to facilitate data sharing between WPC partners. As a result of the TC, CSCHS was able to successfully execute data use agreements with all key partners. The Pilot also implemented a universal WPC consent form used by all partners. Care plans were shared with internal partners using a shared electronic health record (EHR) or Epic, and with external partners via secure file transfer.

CSCHS care coordinators were all clinic-based, and typically used Epic's HealthLink function to support daily care coordination activities. Community health clinics used their own EHR system (e.g. Nextgen) for WPC documentation as well as a WPC Access database to enter services and relevant patient data which were sent via secure file transfer. Periodic data extracts were pulled from partners who used other electronic health records and data systems to support ongoing analysis of the eligible and enrolled population. For CSCHS clinics, with an upgrade to Epic, coordinators received real-time messaging regarding ED and hospital admissions, including Emergency Psychiatric Services (EPS) admissions. The community health clinics were only able to access enrollee's medical data and did not receive real-time notification of key events such as ED utilization. Because CSCHS care coordinators were clinic-based, they also did not access the system remotely.

Standardized organizational protocols to support care coordination. Santa Clara's WPC Pilot developed standardized protocols for referring enrollees to services and monitoring referral statuses. For example, the Behavioral Health Call Center was used to arrange all ambulatory behavioral health appointments. All referrals were tracked using tools within Epic, which sent reminders to care coordinators to follow-up on goals or referrals as needed.

Financial incentives to promote cross-sector care coordination. The Pilot's care coordination services were funded using four different per-member-per-month (PMPM) bundles that reflected differing enrollee needs: short-term care management, mid-term care management, long-term care management and nursing home transitions. Care coordinators working with each enrollee were expected to use their clinical judgement and enrollee goals to determine which bundle enrollees should be assigned to. Bundles were mutually exclusive, but enrollees could move from one bundle to another if needed. Care coordination services were provided both directly by CSCHS and via contracts with external WPC partners. Contracts with external partners included incentive payments that were used to encourage partner participation in the TC and provision of peer navigation services. WPC funds incentivized service providers' adoption into the TC.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Care coordinators used in-person outreach with potential enrollees . This process usually entailed reviewing daily clinic schedules to identify patients with appointments that were eligible for WPC. Care coordinators regularly used downtime during the

appointment (e.g., after the nurse took patient vitals but before the provider saw the patient) to discuss the WPC program with potential enrollees and provided a handout with more information. Following the doctor's visits, the care coordinator would then attempt to enroll the individual by having them sign a WPC authorization form. Following enrollment and development of initial goals, communication between the enrollee and care coordinator was primarily telephonic for most clinics. Some of the community health clinics utilized a service model which included not only telephonic and clinic-based care coordination services but also conducted care coordination services in the home and/or in the field.

Conduct needs assessments and develop comprehensive care plans. Santa Clara's Pilot used several different assessment tools. Health assessments conducted at enrollment include questions related to health and social services needs. Starting in November 2018, CSCHS HealthLink system also included a social determinants of health assessment which the Pilot used to better understand the enrollee's social needs. Care coordinators used all available data (e.g., HUMS score and assessment results) to assign enrollees to PMPM bundles (e.g., short-, mid-, or long-term care management). Starting in November 2018, care coordinators also started using Epic's Healthy Planet longitudinal care plan to store and share care plans within Epic HealthLink.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to ensure enrollees received needed services. For example, CHWs would arrange or accompany enrollees to health appointments when needed. Care coordinators also worked to develop relationships with treatment staff that would allow for warm-handoffs of enrollees.

Promote accountability within care coordination team. Care coordination teams were located within clinics, which allowed for frequent and informal communication between care coordination team members. Accountability for care coordination activities was also tracked in team meetings at the clinic-level and using tools in CSCHS' EHR.

Suggested Citation

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Santa Cruz County

Elaine M. Albertson, MPH, Emmeline Chuang, PhD, Leigh Ann Haley, MPP, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Santa Cruz County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Santa Cruz County Health Services Agency (HSA) worked most closely with several county agencies (Behavioral Health, Clinics Services, and Public Health Divisions; and Human Services and Probation Departments), the managed care plan, and three community partners.

Santa Cruz's WPC Pilot utilized an opt-in enrollment model to facilitate engagement. Eligible enrollees were identified via referrals from partner organizations and self-referral. Length of enrollment varied based on enrollee needs and could range from several months to a year. Enrollees were considered "graduated" from Santa Cruz program once they had fully "stepped down" from the Pilot's service structure, which was based on acuity and intensity. As of early 2019, the Pilot had not yet implemented a formal graduation ceremony but had plans to do so in the future.

The overall characteristics of Santa Cruz's WPC Pilot, called "Cruz to Health," are displayed in Exhibit 1.

Exhibit 1: Santa Cruz WPC Pilot Overview

Lead Entity	County of Santa Cruz, Health Services Agency		
5-Year Projected Enrollment	625		
Enrollment Strategy	Open Referral Process		
Primary Target Population(s)	Chronic Physical Conditions, Severe Mental Illness and/or Substance Use Disorder, High Utilizers, Homeless, At-Risk-Of-Homelessness		
19 Partner Organizations			
7 County Health and Mental Health	1 County Housing, Justice, or Social Services	1 Managed Care Plan	10 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, Santa Cruz's WPC Pilot focused on reducing utilization of avoidable health services

among those with complex medical and behavioral health needs by improving 30-day readmission rates, depression remission, and diabetes and hypertension control.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by multidisciplinary teams led by a case manager supervisor with a social work background. Each team was organized to include diverse specialists (e.g., housing navigators, peer support coaches), while the case manager with social work background served as the primary point of contact for enrollees. In 2019, the Pilot was in the process of hiring a nurse to provide support for enrollees with behavioral health and medical needs through remote monitoring. Average caseload for each case manager was 25 enrollees.

Data sharing capabilities to support care coordination. By early 2019, Santa Cruz County's HSA had established data sharing agreements with all of its partners, primarily because of partners' pre-WPC involvement in the county's Health Information Exchange. The Pilot used multiple different release-of-information forms to gather consent for data sharing from enrollees.

By early 2019, Santa Cruz's WPC Pilot had procured but not yet implemented an electronic case management platform ("Together for Care"). To facilitate data sharing until this platform was fully implemented, the Pilot utilized the electronic health record, Epic, for sharing medical records and Avatar for sharing behavioral health records with internal county partners, and Excel and Access databases to share data with external WPC partners. Case managers were also able to access data using the Health Information Exchange.

To help promote a person-centered approach to enrollee engagement, case managers were able to remotely access data on mobile laptops or other devices in the field. Access to the enrollee care plan was limited to a subset of care team members. As of early 2019, case managers did not receive real-time notifications if enrollees visited the emergency department; however, case managers would receive these notifications once the new electronic case management platform was fully implemented.

Standardized organizational protocols to support care coordination. Santa Cruz's WPC Pilot did not develop standardized protocols for referring enrollees to services or for monitoring and follow-up on the status of these referrals. Each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. Santa Cruz County's HSA was reimbursed for care coordination services primarily through two per-member-per-month (PMPM) bundles, which were assigned based on enrollee need of behavioral health services and/or clinical medical services. Some care coordination services were provided directly by Santa Cruz County's HSA and others via contracts with external service providers. Care coordination contracts with external partners included incentive payments for scheduling primary care and behavioral health appointments within a week of discharge from an inpatient stay, jail, or psychiatric hospitalization.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Case managers were responsible for initiating contact with potential enrollees and scheduling intake meetings with interested individuals. Case managers communicated with enrollees both in-person, in the field, and by telephone. Case managers were expected to contact enrollees on a weekly basis, but reported aiming for daily contact with enrollees actively receiving WPC services.

Conduct needs assessments and develop comprehensive care plans. Case managers performed a formal needs assessment at intake, which was then repeated annually or whenever a significant change in the enrollee's life occurred.

Needs assessment included the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), informal psychosocial assessments and other additional assessments needed to develop a comprehensive care plan with enrollee-driven goals. As of early 2019, care plans were not shared with partners, but the Pilot expected this to change once the new electronic case management platform was implemented.

Actively link patients to needed services across sectors. Case managers used active referral strategies to facilitate enrollee access to needed services. For example, case managers were required to make follow-up appointments with providers and were incentivized to schedule follow-up appointments with primary care and behavioral health providers within seven days of enrollee discharge from hospital or correctional facility.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Santa Cruz's WPC Pilot required case managers to participate in weekly in-person one-on-one supervisorial meetings, weekly meetings for multidisciplinary teams and specialties (e.g., for all case managers), bi-weekly meetings with leadership, and monthly meetings with the emergency department staff.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Santa Cruz County: Santa Cruz County.* Los Angeles, CA: UCLA Center for Health Policy Research.

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Care Coordination in California's Whole Person Care Pilot Program: Shasta County

Leigh Ann Haley, MPP, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Connie Lu, MPH, Brenna O'Masta, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Shasta County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Shasta County Health and Human Services Agency (HHSA) worked most closely with two county agencies (Adult Services Branch and Regional Services Branch), the managed care plan, and two community partners.

Eligible enrollees were identified using internal (i.e., intra-agency) and external referrals, as well as self-referrals obtained as a result of field-based outreach efforts. Shasta had an opt-in enrollment process, and length of enrollment varied based on enrollee needs. On average, the outreach and engagement period took 100 days, followed by a 200-day period of enrollment in WPC services. The program was tiered based on acuity level.

The overall characteristics of Shasta's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Shasta WPC Pilot Overview

Lead Entity		Shasta County Health and Human Services Agency (HHSA)	
5-Year Projected Enrollment		600	
Enrollment Strategy		Referrals	
Primary Target Population(s)		High Utilizers	
9 Partner Organizations			
1 County Health and Mental Health	1 County Housing, Justice, or Social Services	1 Managed Care Plan	6 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, Shasta's WPC Pilot focused on facilitating communication between enrollees and care managers, connecting enrollees to a patient centered medical home, and improving access to housing for enrollees, suicide risk assessment, diabetes control, and depression remission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by multidisciplinary teams, which included master's level case managers, nurses located in partner Federally Qualified Health Centers (FQHCs), and a housing case manager who provided social work and benefits support. The average caseload was 20-25 enrollees.

Data sharing capabilities to support care coordination. By early 2019, Shasta County HHSA implemented a multiparty, bi-directional release of information which allowed for data sharing between partners. This release of information form was included in enrollee's initial referral packet, and reviewed as part of the opt-in enrollment process.

As of mid-2019, Shasta's WPC Pilot was in the process of developing a SharePoint-based system to support case management activities. As a temporary solution, staff tracked and shared data in an electronic database that included data visualization functions, spreadsheets, critical paper documents, and encrypted emails. As appropriate, paper documents were used for documentation and tracking.

Standardized organizational protocols to support care coordination. Shasta's WPC Pilot included standardized protocols and pathways through which the local hospital and county mental health department could refer enrollees to WPC. However, the Pilot did not develop standardized protocols for referring WPC enrollees to needed services, or for monitoring and following up on the status of these referrals. Each care coordinator was responsible to ensure timely referrals and monitoring of receipt of services.

Financial incentives to promote cross-sector care coordination. Some but not all care coordination services were contracted out to external partners, rather than provided directly by Shasta County HHSA. In particular, housing case management was provided by HHSA and medical case management was provided by two health clinics. Shasta County HHSA was reimbursed for care coordination services using two per-member-per-month (PMPM) bundles, one for intensive medical case management and one for housing case management.

Contracts included incentive payments intended to align contractor goals with those of WPC. Example incentives included payments for inputting homeless enrollees' intake information into the Homeless Management Information System (HMIS) and for achieving certain outcomes (e.g., enrollees stayed in housing for at least six months, enrollees had less than two emergency visits in a six-month period).

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Shasta's WPC Pilot used outreach in the field or on-site at an FQHC clinic to initiate contact with eligible enrollees. Care coordinators subsequently communicated with enrollees in multiple ways, including in-person (most common), by phone, and text message. Expectations for frequency of communication varied by enrollee acuity. Tier 1 (highest need) enrollees received communication at least weekly, Tier 2 enrollees received bi-weekly communication, and Tier 3 (lowest need) enrollees received monthly communication.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. A case manager, a nurse, and a housing manager each conducted their own assessments to inform the care plan. Assessments included a PHQ (Patient Health Questionnaire)-9 screening for depression and a suicide risk assessment tool. Assessments directly informed the acuity level determination and tier placement of enrollees; assessments were conducted annually.

After determining the prospective enrollee was eligible for the program, team members developed the care plan based on the assessments completed. Care plans focused on medical and housing needs, but also addressed

other topics such as budgeting or general life skills. Staff consistently evaluated the care plan on an ongoing basis.

Actively link patients to needed services across sectors. Shasta's WPC care coordinators used active referral strategies to refer their enrollees to needed services. For example, case managers often assisted with making appointments and accompanying enrollees to behavioral health, medical services, and social service appointments.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Shasta's WPC Pilot required that the care coordination team meet by phone daily and actively reconnect throughout the week when events occurred. The team used fax and encrypted email to share sensitive information. The SharePoint case management platform was planned to support training and share relevant enrollee information amongst the team.

Suggested Citation

Haley LA, Chuang E, Albertson E M., Lu C, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Shasta County*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Solano County

Brenna O'Masta, MPH, Emmeline Chuang, PhD, Elaine M. Albertson, MPH, Leigh Ann Haley, MPP, Connie Lu, MPH, Nadereh Pourat, PhD

California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Solano County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Solano County Health and Social Services (SCH&SS) worked most closely with other county agencies, the Medi-Cal managed care plan, and with community partners (e.g., community health clinics, medical centers, and housing and substance use treatment providers).

Eligible enrollees were initially identified using administrative data from the managed care plan, and later expanded to accept referrals from emergency departments, clinics, and other community-based organizations. The Pilot made this change because the time delay in the data meant not all individuals identified as high utilizers on the managed care plan's list were actually eligible for WPC, and because of difficulty engaging administratively identified enrollees in services.

The overall characteristics of Solano's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Solano WPC Pilot Overview

Lead Entity		Solano County Health and Social Services (SCH&SS)	
5-Year Projected Enrollment		250	
Enrollment Strategy		Referrals and Administrative Data	
Primary Target Population(s)		High Utilizers, Severe Mental Illness and/or Substance Use Disorder	
12 Partner Organizations			
4 County Health and Mental Health	0 County Housing, Justice, or Social Services[1]	1 Managed Care Plan	7 Community Partners[2]

Notes: [1] The lead entity performs one or more of these functions. [2] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, Solano's WPC Pilot focused on increasing screening for depression and suicide, improving housing support services, engaging primary care providers, and reducing avoidable hospital usage.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a multidisciplinary team that included a master's level clinician serving as a program manager, three master's level social workers, two peer outreach specialists, a housing coordinator, a mental health and substance use disorder specialist, and an employment specialist. The Pilot deliberately included peer outreach specialists with personally lived experiences similar to that of WPC target populations to help improve enrollee engagement. Average care coordinator caseload was approximately 20 enrollees.

Data sharing capabilities to support care coordination. By 2019, SCH&SS had executed data sharing agreements with most partners, with a few being finalized, and also implemented a universal consent form that covered all WPC partner organizations.

All key WPC partners utilized the same electronic data system, ETO, which contained case management data and not medical or behavioral health information. ETO was used by the care coordinators to perform all daily care coordination activities. To help promote a person-centered approach to enrollee engagement, care coordinators were able to access ETO remotely, in the field.

Standardized organizational protocols to support care coordination. Solano's Pilot included standardized protocols in its electronic data system for referring enrollees to needed services and monitoring referral status. Care coordinators tracked referrals and placements, and also made lists of action items to aid in monitoring progress and following up.

Financial incentives to promote cross-sector care coordination. SCH&SS was reimbursed for WPC care coordination services primarily through a single per-member per-month (PMPM) bundle that paid a set amount per enrolled person for care coordination. The PMPM bundle was designed to not be duplicative of the Medi-Cal targeted case management (TCM) benefit, and focused instead on funding activities such as peer support, multidisciplinary meetings, and field engagement. All care coordination services were provided through contracts with an external service provider.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Solano's Pilot used in-person communication to initiate contact with eligible enrollees, often at the hospital or in the community. Enrollees were classified based on levels of acuity, and expected frequency of communication varied accordingly. For example, care coordinators were expected to contact high acuity enrollees on a nearly daily basis while those with lower acuity might only be contacted once per month (though more often if needed).

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake, and typically repeated assessments at least once per year and more frequently when warranted. Assessments were also repeated before the enrollee could graduate from the program. Instruments used included the PHQ-9 screener for depression, and a biopsychosocial assessment. Care coordinators used the assessments and collaborated with the enrollee and other members of the care team to develop a care plan that was shared with all relevant partners using ETO.

Actively link patients to needed services across sectors. Solano's WPC care coordinators used active referral strategies to refer their enrollees to needed services. Care coordinators assisted clients with making appointments, arranged transportation as needed, and helped clients navigate the referral process.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, Solano's Pilot required regularly scheduled meetings among the care coordination team,

supported by the program manager. Care coordinators were typically expected to attend two weekly meetings to discuss their caseloads. Additionally, care team members communicated with one another by phone, text message, and email.

Suggested Citation

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Health Policy Case Study

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Care Coordination in California's Whole Person Care Pilot Program: Sonoma County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Sonoma County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, Sonoma Behavioral Health worked most closely with two county agencies (Human Services and Health Services) and Sonoma County's managed care plan. For WPC, Sonoma established new relationships with six Federally Qualified Health Centers (FQHCs).

Eligible enrollees were identified using referrals, primarily from FQHCs, but also from the county and other community partners. Length of enrollment depended on the individual's progress in achieving agreed upon goals.

The overall characteristics of Sonoma's WPC Pilot are displayed in Exhibit 1.

Exhibit 1: Sonoma WPC Pilot Overview

Lead Entity		County of Sonoma-Department of Health Services, Behavioral Health Division	
5-Year Projected Enrollment		2,100	
Enrollment Strategy		Referrals	
Primary Target Population(s)		Severe Mental Illness and/or Substance Use Disorder, Homeless, At-Risk-Of-Homelessness	
17 Partner Organizations			
2 County Health and Mental Health	2 County Housing, Justice, or Social Services	1 Managed Care Plan	12 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goal of better care and better health, Sonoma Behavioral Health focused on improving suicide risk assessment, jail recidivism, housing services support, and reducing 30-day readmission rates.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were primarily provided "in-house" by a case manager supported by a larger interdisciplinary team that included but was not limited to behavioral health clinicians, a benefits eligibility worker, a social

services worker, and peer outreach workers. Case managers had expertise in a wide variety of domains and served as the primary contact for enrollees, but relied on behavioral health clinicians for support and to write 51/50 holds, when needed. Eligibility and social services workers helped facilitate applications and connection to benefits assistance and social service programs as needed. To improve integration of primary care and behavioral health services, WPC care managers were each assigned to one FQHC, and responsible for coordinating activities with a FQHC nurse. As of early 2019, each care manager was assigned a caseload of no more than 15 clients, though Sonoma Behavioral Health considered increasing this number in the future.

Data sharing capabilities to support care coordination. By early 2019, Sonoma Behavioral Health established data use agreements with health plans to validate eligibility and target population criteria. Sonoma's Pilot also enabled data sharing between many of its partners, including: Community Development Commission (coordinated entry and access to Homeless Management Information System), participating FQHCS, Redwood Community Health Coalition, and a local substance use treatment provider. To facilitate data sharing, Sonoma implemented a universal consent form among many WPC partner organizations. A limited number of partner organizations did not agree to use the WPC universal consent.

Sonoma Behavioral Health utilized two main data sharing platforms to facilitate daily care coordination activities: TAP (cloud based screening tool used by Sonoma staff and FQHCs) and Watson Care Management (data sharing and case management platform). TAP contained all screening assessment and questionnaire data for clients, and was also used to store and share client records, such as consent forms, health records, etc. Watson Care Management was a new, web-based system that went live in 2018. The system was used to house care plans and integrated data from four source systems (Probation, Human Services, Behavioral Health, and Substance Use Disorder). Care coordinators could access this system remotely and update it in real-time. Because community partners utilized different data systems, data sharing with these partners typically occurred through in-person meetings; however, the Pilot expressed interest in ensuring all partners could access Watson Care Management in the future.

Standardized organizational protocols to support care coordination. Sonoma's Pilot included standard protocols for referring enrollees to needed services, monitoring referral status, and documenting any follow-up. These protocols were drawn from established referral pathways from a previous program (Community Intervention Program).

Financial incentives to promote cross-sector care coordination. Care coordination services were provided both directly by Sonoma Behavioral Health (Behavioral Health, Social, Housing, Substance Use and Financial Services), and via contracts with partners including FQHCs (medical, legal and housing services). Sonoma Behavioral Health was reimbursed for services using one per-member-per-month (PMPM) bundle (Intensive Case Management (ICM), and one fee-for-service (outreach and engagement). Outreach and Engagement services focused on preparing and introducing enrollees to the concept of case management, whereas ICM services entailed actual provision of case management.

When contracting out services to external partners, Sonoma Behavioral Health included incentive payments to align contractor goals with those of WPC. For example, beginning in 2018, incentives were available to FQHCs for 1) the hiring and retention of nursing staff for outreach and engagement and case management activities and 2) reaching pre-specified pay for performance goals.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Sonoma's Pilot used a variety of methods to initiate contact with eligible enrollees. Referrals into the program came from a variety of sources including: community based organizations, county agencies, the county jail, and FQHCs. Once a referral was received, a Clinical Health Program Manager reviewed and assigned the referral to a single case manager. Case managers extensively screened potential enrollees and built relationships, trust, and rapport, primarily in the field and to a lesser extent by telephone. Continuing communication with the enrollee occurred largely by phone and in-person, particularly in a clinic. Case managers were required to contact enrollees face-to-face at least once per month. However, in practice, enrollees were contacted more frequently than that by one or more care coordination team members identified in their comprehensive care plan.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake. Enrollees received a comprehensive needs assessment to determine: 1) Medi-Cal eligibility, 2) homelessness/at risk of homelessness, based on HUD definition, 3) mental health, 4) substance use disorder, 5) chronic conditions, 6) high utilizers of multiple systems (as determined by medical records) and 7) involvement in criminal justice system. Different components of the needs assessment were administered by different case management team members. Results directly informed development of the comprehensive care plan with actionable, client-centered goals. Everyone on the care team had access to the care coordination plan through Watson Care Management; internal partners had read-write capabilities, while external partners had read only access.

Actively link patients to needed services across sectors. Sonoma's WPC case managers used active referral strategies and referred their enrollees to needed services. Due to small caseloads, case managers often accompanied enrollees to their appointment. Additionally, specialized members of the care team ensured that enrollees applied for all eligible social services. Sonoma's Pilot also assigned team members to dedicated regions in the county on certain days, to make troubleshooting referrals easier.

Promote accountability within care coordination team. In order to ensure accountability within the care coordination team, care managers frequently reviewed client goals with their care team and client to ensure progress was being made. The responsible team member was held accountable for ensuring that all referrals were completed and any required follow-up was arranged. Case managers and their teams were responsible for participating in weekly meetings with nurse counterparts at their assigned FQHC, and also engaged in frequent communication through phone and email, as needed. Sonoma's Pilot found in-person meetings most effective for building relationships needed to effectively coordinate care.

Suggested Citation

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Care Coordination in California's Whole Person Care Pilot Program: Ventura County

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California's Whole Person Care (WPC) Pilot Program implemented under the Section 1115 Medicaid Waiver was designed to coordinate medical, behavioral, and social services to improve the health and well-being of Medicaid beneficiaries with complex needs. As part of the WPC evaluation, we developed a framework to assess elements of cross-sector care coordination implemented by the WPC Pilots (found here). The following document describes care coordination under Ventura County WPC Pilot using this framework from implementation to March 2019.

Background

To implement WPC, the Ventura County Health Care Agency (VCHCA) worked most closely with other county agencies (Behavioral Health Department, Continuum of Care, Human Services Agency, and Medical Center), the Medi-Cal managed care plan, and one community partner (e.g., service providers for individuals experiencing homelessness).

Initially, Ventura's Pilot used administrative data from the Medi-Cal managed care plan to identify potential enrollees and then attempted to contact them by telephone and/or in the field. In addition, the Pilot also employed a referral-based system in which eligible enrollees were primarily identified through referrals from community partners. This referral-based approach allowed patient engagement closer to the point of care and at a time of established need, resulting in a higher referral completion rate.

The overall characteristics of Ventura's WPC Pilot called "Ventura County Whole Person Care Connect Pilot" are displayed in Exhibit 1.

Exhibit 1: Ventura WPC Pilot Overview

Lead Entity		Ventura County Health Care Agency (VCHCA)	
5-Year Projected Enrollment		2,546	
Enrollment Strategy		Referrals and Administrative Data	
Primary Target Population(s)		High Utilizers	
38 Partner Organizations			
7 County Health and Mental Health	9 County Housing, Justice, or Social Services	1 Managed Care Plan	21 Community Partners[1]

Notes: [1] Community partners include services for housing, health, mental health, and alcohol and other drug dependence and city/municipal partners that were not part of the lead entity's organization.

To achieve the goals of better care, timely access and better health, Ventura's Pilot focused on reducing unnecessary emergency room visits and hospital readmissions, improving housing support services, diabetes and hypertension management control, depression remission,

suicide risk assessment and administrative objectives around staff training and service intensity.

Care Coordination Infrastructure

Care coordination staffing that meets patient needs. Care coordination services were provided by a multidisciplinary team tailored to the needs of each client. Multidisciplinary team members included community health workers (CHWs), clinical staff such as nurses, behavioral health practitioners, and addiction specialists. Community Health Workers (CHWs) were the primary point of contact for each enrollee and provided specialized supports such as field-based benefits enrollment and housing support services. The Pilot deliberately included CHWs with lived experiences similar to that of WPC target populations and representative of the communities served to help improve enrollee engagement. Average care coordinator caseload was approximately 60 enrollees, consisting of a mix of higher and lower acuity enrollees.

Data sharing capabilities to support care coordination. By 2019, VCHCA had executed data sharing agreements with some partners. Data sharing agreements and/or internal procedures across affiliated agencies were established to facilitate sharing of health, mental health, and substance abuse treatment information; housing data were handled separately. Ventura's Pilot also implemented a universal consent form to facilitate data sharing across WPC partner organizations.

Care coordinators used multiple databases to support daily care coordination activities, including a Cerner electronic health record (EHR) for medical data, an Avatar data system for behavioral health data, the Homeless Management Information System for housing services data, and an Access database for tracking enrollment information. Ventura's Pilot planned to launch an integrated data system that would unify these sources into a single platform, but had not yet implemented this system as of early 2019.

To help promote a person-centered approach to enrollee engagement, care coordinators were able to access client data on touchscreen laptops and phones with access to WiFi in the field. Care coordinators also received real-time notifications of emergency room and hospital admissions and discharges at Ventura County Medical Center and Santa Paula hospital.

Standardized organizational protocols to support care coordination. Ventura's Pilot included standardized protocols for referring enrollees to needed services. The Pilot used "Lean 6 process mapping" to identify key partners and referral pathways. Ventura's Pilot also included standardized protocols for monitoring and following up on referrals.

Financial incentives to promote cross-sector care coordination. VCHCA was reimbursed for WPC care coordination services primarily through three risk-stratified per-member-per-month (PMPM) bundles: engagement, care coordination, and field-based care coordination. Administrative data and needs assessments informed risk designation and subsequent assignment of enrollees to specific PMPM bundles. Care coordination services were provided directly by VCHCA and through extensive partnerships with collaborative service providers. Incentives encouraged care coordination through payments for developing care plans within 30 days and following up after emergency department visits.

Care Coordination Processes

Ensure frequent communication and follow-up to engage enrollees. Initial field-based outreach was conducted in the community, either in response to referrals, at specific events or on the street. Once enrolled in WPC, care coordinators communicated with enrollees in-person as well as by phone and text message. Care coordinators were expected to contact enrollees at least once a month by phone, and in person at least once every other month. In practice, frequency of contact varied by enrollee needs and acuity. In particular, enrollees identified as "super utilizers" based on

administrative utilization data were identified and subsequently received more contact.

Conduct needs assessments and develop comprehensive care plans. Care coordinators performed a formal needs assessment at intake and updated every 90 days (central care coordination bundle) and annually thereafter. In addition, all enrollees with a recent emergency department or hospital visit received a weekly comprehensive case review that was made available to care coordinators in the electronic health record. Needs assessments and enrollee input directly informed development of comprehensive care plans and associated goals.

Actively link patients to needed services across sectors. Care coordinators used active referral strategies to refer enrollees to needed services. For example, care coordinators could assist with establishing a primary care provider, scheduling appointments, arrange follow-up after hospital visits, help coordinate transportation to appointments, attend appointments with enrollees as their advocate, and assist with applications for housing and employment and benefits programs.

Promote accountability within care coordination team. In order to ensure accountability and collaboration within the care coordination team, Ventura's Pilot team members participated in daily huddles to discuss clients and care plans, and in weekly case conferences led by the WPC program's medical director.

Suggested Citation

Albertson E M., Chuang E, Lu C, Haley LA, O'Masta B, Pourat N. 2019. *Care Coordination in California's Whole Person Care Pilot Program: Ventura County*. Los Angeles, CA: UCLA Center for Health Policy Research.

Appendix N: Lead Entity Survey Instrument

Introduction and Instructions

The UCLA Center for Health Policy Research was selected by California Department of Health Care Services to evaluate the Whole Person Care (WPC) pilot program. This questionnaire is intended to assess how participating Lead Entities (LEs) have implemented the Pilot and to understand your efforts towards achieving WPC program goals.

This questionnaire is comprised of a mix of closed- and open-ended questions, and is divided into the following domains:

1. Respondent Information
2. The Local Context
3. Motivation for WPC
4. WPC Infrastructure and Resources
5. WPC Implementation
6. WPC Leadership, Communication, and Decision-Making Processes
7. Inter-agency Collaboration
8. Identifying and Retaining Eligible Beneficiaries
9. Perceived Impact of WPC
10. WPC Program Monitoring, Feedback, and Performance Improvement
11. WPC Learning Collaborative

This questionnaire is to be completed by the individual(s) most knowledgeable in implementing the WPC program **within the LE institution**, which may include one or more persons depending on the LE. The questions are intended to be distinct from LEs mid-year and annual reports to DHCS and narrowly focused on specific issues. In completing this questionnaire, **please focus on the LE perspective**. A separate companion questionnaire will solicit partner perspectives.

You can distribute the PDF version of this questionnaire to the most knowledgeable individual(s) **within the LE institution** to complete the relevant sections of the survey. However, we ask that all responses are entered online by one individual due to limitations of our online data system (SurveyMonkey). We anticipate that this questionnaire will take about 2-3 hours to complete.

For ease, please enable cookies on your browser. With cookies enabled, responses will be saved prior to submission of the questionnaire as long as the respondent uses the same computer and browser.

Confidentiality. Your responses on this questionnaire will be confidential. Only the UCLA evaluation team will have access to your individual responses. Only aggregated data will be included in evaluation reports and publications. **Your responses to this survey will not impact your WPC funding from DHCS.**

The evaluation team are available to answer your questions if needed. Please contact the UCLA evaluation team at wpc@chpr.em.ucla.edu with questions.

Domain 1: Respondent Information

1) Name of your LE organization: _____

This survey is focused on the LE perspective, and should be filled out by the individual(s) within the LE organization that are most knowledgeable about WPC. We realize there may be considerable variation across LEs in who these individual(s) may be. To provide context for survey responses, please provide the names of all individual(s) within the LE organization that completed the survey, their title and (if applicable) the LE department or division in which they are located, and their role in WPC (e.g., WPC program manager).

2) Names of Individual(s) within the LE completing this survey:

Name	Title	Department/Division (if applicable)	Role in WPC	Email/Contact Info	Questionnaire Domain(s) Addressed

3) On average, how often has your LE organization participated in meetings with WPC partners about the WPC pilot program during planning and implementation phases of WPC? We understand that each pilot will have different workgroup

compositions and titles, but please try to fit your partner meetings into the categories described below. Any concerns can be noted in the comment section.

	Planning phase	**Implementation phase**
Meeting type		
Executive / steering committees	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other (please specify _____) ☐ Does not apply	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other (please specify _____) ☐ Does not apply
Data governance and sharing committees	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other (please specify _____) ☐ Does not apply	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other (please specify _____) ☐ Does not apply
Operation committees	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other (please specify _____) ☐ Does not apply	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other (please specify _____) ☐ Does not apply

If you would like to comment on any of the items above, please specify and do so here:

Domain 2: The Local Context

This section asks questions about the environment under which WPC is being implemented, in particular which initiatives your LE was already participating in prior to or during WPC.

1) Is your LE participating in any other initiatives similar to WPC (e.g., similar goals, services, and/or clients/patients served)? **[If no, skip to Domain 3].**
   - ☐ No
   - ☐ Yes

1a. **[If yes]** Please provide the name of the initiative, funding sources (if applicable), approximate time frame (start and end dates), and extent to which there is synergy between this initiative and WPC. Examples of initiatives that could be similar to WPC: PRIME, Health Homes, and Full Service Partnerships.

Name of Initiative	Source(s) of funding:	Approximate time frame (start and end date):	On a scale from 0 to 10, where 0=No synergy and 10=Extremely high synergy, please indicate the extent to which there is synergy between this initiative and WPC?

Domain 3: Motivation for WPC

The following questions relate to perceived benefits of participating in the WPC program and how WPC fits with your LE's mission and overall strategic goals.

1) Please rate on a scale of 0 to 10, where 0=Not at all important and 10=Very important, the importance of the following to your LE's decision to participate in WPC. If a particular element is not applicable, please select N/A and explain in the comment section.

	N/A	0 = Not at all important	1	2	3	4	5 = Neither important nor unimportant	6	7	8	9	10 = Very important	Comment
a. Synergy with existing programs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Consistency with organizational goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Improve integration of care for clients/patients with multiple needs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Develop collaborative relationships with participating WPC entities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Continue/maintain existing relationships with participating WPC entities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Getting necessary services for clients/patients	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Getting client/patient referrals from	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Not at all important	1	2	3	4	5 = Neither important nor unimportant	6	7	8	9	10 = Very important	Comment
participating WPC entities													
h. Ease of implementation (e.g., due to concordance with existing processes of care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Low resource requirements (e.g., lowest cost, least staff time to implement)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Reduce cost of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Improve quality of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
l. Other (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

2) On a scale from 0 to 10, where 0=Very low and 10=Very high, please indicate the extent to which each of the following WPC pilot program goals and/or program components fits with your LE's overall strategic priorities. If a particular element is not applicable, please select N/A and explain in the comment section.

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
a. Manage the care of high risk and high utilizing populations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
b. Use of case management to manage health care utilization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Earlier identification of patient/client needs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Identify clients/patients receiving services from more than 1 system	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Reduce inappropriate emergency department visits and hospitalizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Improve quality of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Coordinate health, behavioral health and social services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Sharing data with external partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Increase client/patient access to housing and supportive services (e.g., housing navigation, tenancy support)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Increase client/patient access to other social services (e.g., employment assistance, TANF, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
k. Increase client/patient access to mental health and/or substance abuse treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

3) On a scale from 0 to 10, where 0=Very low and 10=Very high, please indicate the extent to which WPC program implementation is a priority for your organization.

0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 4: WPC Infrastructure and Resources

This section asks questions around infrastructure and resources related to WPC activities. We are interested in learning about infrastructure and resources in place prior to WPC as well as efforts to develop additional infrastructure as part of WPC.

4) Please indicate whether your LE organization participated in **any** of the following activities with **INTERNAL** WPC partners prior to WPC and/or whether you are planning to implement **any** of these activities as part of WPC. Internal partners are organizations that work under the same umbrella agency as yours such as county hospital or county mental health department. If a particular element is not applicable, please select N/A. (Select all that apply)

	Prior to WPC	Part of WPC	N/A	Comment
a. Business associate agreements or memorandum of understanding	☐	☐	☐	
b. Date use or sharing agreements	☐	☐	☐	
c. Electronic sharing of client/patient information via a centralized data warehouse and/or a query-based record locator (e.g., health information exchange)	☐	☐	☐	
d. Bi-directional electronic referral	☐	☐	☐	
e. Shared electronic system for tracking care management services	☐	☐	☐	
f. Standardized electronic intake forms	☐	☐	☐	
g. Standardized diagnostic and/or evaluation or assessment tools	☐	☐	☐	
h. Standardized client/patient referral protocols	☐	☐	☐	

	Prior to WPC	Part of WPC	N/A	Comment
i. Real-time access to client/patient data by providers/staff	☐	☐	☐	
a. Shared coordinated assessment system to identify high risk/need clients/patients and prioritize receipt of services	☐	☐	☐	
b. Use of shared care navigators or care coordinators to guide clients/patients receiving care	☐	☐	☐	
c. Co-location of providers or staff to facilitate access to services and/or resources	☐	☐	☐	
d. Multidisciplinary teams comprised of providers and/or staff from multiple organizations	☐	☐	☐	
e. Warm hand-offs of clients/patients to partners	☐	☐	☐	
f. Case conferences including multidisciplinary providers and staff to discuss joint care	☐	☐	☐	
g. Other (please specify _____)	☐	☐	☐	

5) Please indicate whether your LE participated in any of the following activities with **EXTERNAL** WPC partners prior to WPC and/or whether you are planning to implement any of these activities as part of WPC. External partners are organization outside your umbrella agency such as health plans, community clinics, county probation/law enforcement, housing service providers, etc. If a particular element is not applicable, please select N/A. (Select all that apply)

	Prior to WPC	Part of WPC	N/A	Comment

	Prior to WPC	Part of WPC	N/A	Comment
a. Business associate agreements or memorandum of understanding	☐	☐	☐	
b. Date use or sharing agreements	☐	☐	☐	
c. Electronic sharing of client/patient information via a centralized data warehouse and/or a query-based record locator (e.g., health information exchange)	☐	☐	☐	
d. Bi-directional electronic referral	☐	☐	☐	
e. Shared electronic system for tracking care management services	☐	☐	☐	
f. Standardized electronic intake forms	☐	☐	☐	
g. Standardized diagnostic and/or evaluation or assessment tools	☐	☐	☐	
h. Standardized client/patient referral protocols	☐	☐	☐	
i. Real-time access to client/patient data by providers/staff	☐	☐	☐	
a. Shared coordinated assessment system to identify high risk/need clients/patients and prioritize receipt of services	☐	☐	☐	
b. Use of shared care navigators or care coordinators to guide clients/patients receiving care	☐	☐	☐	
c. Co-location of providers or staff to facilitate access to services and/or resources	☐	☐	☐	
d. Multidisciplinary teams comprised of providers and/or staff from multiple organizations	☐	☐	☐	
e. Warm hand-offs of clients/patients to partners	☐	☐	☐	

	Prior to WPC	Part of WPC	N/A	Comment
f. Case conferences including multidisciplinary providers and staff to discuss joint care	☐	☐	☐	
g. Other (please specify _____)	☐	☐	☐	

6) Do you participate in a health information exchange? **[If no, skip to Domain 5].**
   a. ☐ Yes
   b. ☐ No

7) If you have participated in a health information exchange (HIE) prior to WPC and/or will participate in an HIE as part of WPC, please answer the following questions.
   a. Please specify the names of the health information exchange: _____
   b. Please indicate which agencies in your local government participate in the HIE (Select all that apply):
      ☐ Health services agency
      ☐ Mental health agency
      ☐ Substance abuse agency
      ☐ Human service agency (e.g., housing)
      ☐ Probation/law enforcement
      ☐ Other (please specify: _____)

   c. Please provide the year when your lead entity first began participating in the HIE (or anticipated start date if planned):
      Date: MonthMonth YearYear

   d. Please indicate the type of data architecture model of this HIE:
      ☐ Centralized 1: Centralized via County infrastructure/EHR

☐ Centralized 2: Centralized via third party organization

☐ Federated/decentralized (i.e., client/patient data owned and stored locally at point of service)

☐ Hybrid model (a cross between the centralized and federated architecture, e.g., where some data stored in a centralized data repository)

☐ Other (please specify: _____)

e. Please specify what type of data is currently shared in your HIE (Select all that apply):

☐ Demographic data

☐ Medication history (e.g., medication prescribed)

☐ Lab and imaging results

☐ Health care encounter/visit data

☐ Mental health treatment encounter/visit data

☐ Substance abuse treatment encounter/visit data

☐ Other service encounter/visit data (e.g., social services)

☐ Client/patient medical history

☐ Other data on social determinants of health (e.g., income, employment, housing)

☐ Event-based notifications/alerts

☐ Other (please specify: ____)

f. Does the HIE under WPC have the following functionalities (select all that apply)?

☐ Aggregating data and reporting

☐ Track eligibility and enrollment

☐ Event notifications/alerts (e.g., to PCP upon hospital discharge)

☐Tracking enrollees across various systems

If you would like to comment on any of the items above, please specify and do so here:

Domain 5: WPC Implementation

The questions in this section asks about implementation of the core components (as outlined in Attachment HH to the WPC Special Terms and Conditions) and overall implementation strategies as outlined in your LE's WPC application. Please answer these questions from the perspective of the LE.

1) Overall, on a scale from 0 to 10 where 0=Not at all and 10=Very much, how much have you had to change organizational policies and practices in order to implement WPC?

0 = Not at all	**1**	**2**	**3**	**4**	**5 = Neither low nor high**	**6**	**7**	**8**	**9**	**10 = Very much**	**Comment**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

2) Please rate the overall level of effort required of your LE to implement the following WPC program activities on a scale where 0 =Very low and 10 =Very high. If you are not engaged in a specific activity, please select N/A.

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
a. WPC data governance (i.e., management of data being shared as part of WPC)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Other WPC program governance (e.g., participation in committee meetings)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Recruiting or hiring providers/staff to deliver WPC services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Ensuring sufficient physical space and/or other administrative infrastructure necessary to implement WPC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Executing Data Use Agreements (DUA) or Business Associate Agreements (BAAs) with LE and/or other WPC partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Data sharing with LE and/or other WPC partners for community needs assessment and program planning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Data sharing with LE and/or other WPC partners to track WPC program results/outcomes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Data sharing with LE and/or other WPC partners to identify opportunities to improve the WPC program	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
i. Coordinating or integrating WPC activities with health plan partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Delivering WPC services (e.g., case management, housing navigation and tenancy support, linkage to re-entry, substance use disorder or mental health treatment, or other support services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Identifying eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
l. Engaging eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
m. Meeting WPC reporting requirements and timelines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

3) On a scale from 0 to 10 where 0=Very low and 10=Very high, please rate the extent to which turnover or other changes to leadership within your LE has posed challenges to implementing WPC?

0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

4) On a scale from 0 to 10 where 0=Very low and 10=Very high, please rate the extent to which turnover or other staffing changes within your LE has posed challenges to implementing WPC?

0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

5) We are interested in learning about the ways in which your WPC program has changed from what was proposed in your original WPC application. Please rate the extent to which each of the following have changed over time on a scale of 0 =Not at all and 10 =Very much. If not applicable to your WPC program, please select N/A.

	N/A	0 = Not at all	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very much	Comment
a. WPC program goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. WPC program governance structure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Services delivered (e.g., case management, housing assistance, other support services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Process(es) for sharing data with WPC partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Process(es) for identifying or enrolling eligible beneficiaries in WPC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Process(es) for engaging and retaining eligible beneficiaries in WPC program(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Not at all	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very much	Comment
g. Universal or administrative metrics used to track and report WPC outcomes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Other (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

6) On a scale from 0 to 10, where 0=Very low and 10=Very high, how would you characterize overall buy-in for data sharing and/or care coordination activities among each of the following categories of partners? If not applicable to your WPC program, please select N/A.

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
a. Health plans	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Hospitals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Other health care providers (e.g., community health centers)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Mental health providers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Substance abuse treatment providers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Housing providers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Justice system	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
h. Other social service providers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Other (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

7) How is your LE using shared data as part of the WPC program (Select all that apply)?

☐ Inform collaborative community needs assessment with partners

☐ Inform collaborative program planning with partners

☐ Identify target populations

☐ Identify eligible Medi-Cal beneficiaries

☐ Provide real-time data access for providers/staff to use in developing care plans and/or coordinating care for clients/patients

☐ Support workflows for care transitions across different service settings

☐ Inform quality improvement efforts with partners

☐ Track and provide feedback to partners

☐ Other (please specify _____)

Domain 6: WPC Leadership, Communication, and Decision-Making Processes

The questions in this section ask about WPC collaborative leadership, communication and decision-making processes. The entities that comprise the WPC's leadership were defined in your WPC application Please answer these questions from the perspective of the LE.

1) To what extent do you agree / disagree with the following statements about WPC leadership, communication, and decision-making processes. Please answer these questions from the perspective of the LE organization; partners' perspectives will be assessed via a separate survey.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Comment
a. All participating WPC partners are involved in discussion about WPC	☐	☒	☐	☐	☐	
b. WPC leadership team has clear and explicit procedures for making important decisions	☐	☐	☐	☐	☐	
c. WPC decision-makers share ideas and information with partners	☐	☐	☐	☐	☐	
d. WPC partners willingly collaborate and cooperate with each other	☐	☐	☐	☐	☐	
e. My organization is informed as often as it should be about what is happening in WPC	☐	☐	☐	☐	☐	
f. Communication among WPC LE and partners happens both at formal meetings and informally	☐	☐	☐	☐	☐	
g. WPC partners have a clear sense of their roles and responsibilities in relation to the program	☐	☐	☐	☐	☐	

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Comment
a. All WPC partners have a clear and shared vision of how to achieve WPC program outcomes	☐	☐	☐	☐	☐	
b. All WPC partners are in agreement about WPC priorities	☐	☐	☐	☐	☐	
c. All WPC partners are in agreement about the best strategies to pursue to achieve WPC priorities	☐	☐	☐	☐	☐	
a. WPC leadership team is effective at keeping all WPC partners focused on tasks and objectives	☐	☐	☐	☐	☐	
b. WPC leadership team is skillful at resolving conflicts between WPC partners	☐	☐	☐	☐	☐	
a. The WPC partners represent all types of organizations needed to successfully achieve program goals.	☐	☐	☐	☐	☐	
b. The WPC partners represent an appropriate cross-section of those who have a stake in the goals of WPC.	☐	☐	☐	☐	☐	
c. The level of commitment among all WPC partners is high.	☐	☐	☐	☐	☐	
a. We are able to keep up with all the work necessary to implement WPC.	☐	☐	☐	☐	☐	
My organization has had significant influence in the following WPC activities:						

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Comment
a. Defining partner roles and responsibilities	☐	☐	☐	☐	☐	
b. Customizing/adapting WPC goals to fit the needs of the local community	☐	☐	☐	☐	☐	
c. Determining how WPC funding will be allocated to ensure completion of WPC activities	☐	☐	☐	☐	☐	
d. Determining how WPC services will be delivered to clients/patients	☐	☐	☐	☐	☐	
a. WPC enrollees are a small portion of my organization's clients/patients	☐	☐	☐	☐	☐	
b. WPC enrollees use a disproportionate level of resources compared with the rest of my organization's clients/patients	☐	☐	☐	☐	☐	
c. Currently available funding is not sufficient to cover organizational costs of implementing all WPC activities.	☐	☐	☐	☐	☐	

Domain 7. Inter-Agency Collaboration

The following questions address inter-agency collaboration and interactions with WPC partners, specifically in regards to how those relationships changed over the course of the WPC implementation.

1) Please indicate the ways in which *your LE* interacted with each of the following WPC partners PRIOR to WPC. Please select all that apply

Partner organizations	**None / no prior interaction**	**Planning**	**Administration**	**Service Delivery**			**Other (please specify in comments including partner name)**
		Joint advocacy or other joint planning (e.g., as part of a community coalition)	**Data sharing (e.g., for client/patient care, needs assessment)**	**Client/patient referrals**	**Communication about client/patient needs or care**	**Joint service delivery (e.g., you deliver part of a service and contract for the rest)**	
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Partner organizations	None / no prior interaction	Planning	Administration	Service Delivery			Other (please specify in comments including partner name)
		Joint advocacy or other joint planning (e.g., as part of a community coalition)	Data sharing (e.g., for client/patient care, needs assessment)	Client/patient referrals	Communication about client/patient needs or care	Joint service delivery (e.g., you deliver part of a service and contract for the rest)	
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Comment(s):

2) Please indicate the ways in which *your LE* CURRENTLY interacts with each of the following WPC partners. Please select all that apply.

Partner organizations	None / no prior interaction	Planning	Administration	Service Delivery			Other (please specify in comments including partner name)
		Joint advocacy or other joint planning (e.g., as part of a community coalition)	Data sharing (e.g., for client/patient care, needs assessment)	Client/patient referrals	Communication about client/patient needs or care	Joint service delivery (e.g., you deliver part of a service and contract for the rest)	
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Comment(s):

Domain 8: Identifying and Retaining Eligible Beneficiaries

This section addresses questions on how target populations and eligible beneficiaries are identified and retained for the WPC program. Please answer each question in relation to WPC instead of what your organization might have been doing prior to WPC, unless specifically requested to do so.

1) Please indicate whether your WPC program is "opt-in" (eligible beneficiaries choose to enroll) or "opt-out" (all eligible beneficiaries enrolled until they choose to opt out).

☐ Opt in
☐ Opt out

Please describe your method for enrolling beneficiaries in your WPC program.

2) On a scale from 0 to 10 where 0 =Not difficult and 10 =Extremely difficult, please indicate how difficult it has been to identify eligible beneficiaries, enroll eligible beneficiaries, and/or engage or retain eligible beneficiaries in WPC program(s)?

a. Identify eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

b.	Enroll eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c.	Engage or retain eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 9: Perceived Impact of WPC

The questions in this section ask about the perceived impact of WPC thus far (e.g., in achieving programmatic goals, improving care for clients/patients, and/or improving other organizational outcomes). Unless specifically requested to do so, please answer each question from the perspective of the LE.

1) On a scale from 0 to 10, where 0=Not effective and 10=Extremely effective, please indicate how effective the WPC program has been thus far at achieving the following goals: [ADD DO NOT KNOW option]

	Unknown	0 = Not effective	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely effective	Comment
a. Manage the care of high risk and high utilizing populations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Increased use of case management to manage health care utilization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Earlier identification of client/patient needs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Improve identification of clients/patients receiving services from more than one system	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Reduce inappropriate emergency department visits and hospitalizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Improve quality of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Unknown	0 = Not effective	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely effective	Comment
g. Improve coordination of health, behavioral health and social services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Increased data sharing between LE and partners (external and internal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Increase client/patient access to housing and supportive services(e.g., housing navigation, tenancy support)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Increase client/patient access to mental health and/or substance abuse treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

2) Please indicate the extent to which the following areas have improved for the LE's clients/patients as a result of participating in WPC: [ADD DO NOT KNOW option]

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
a. Coordination of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Continuity of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Access to needed services (health, behavioral health, and/or social services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
d. Access to affordable housing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Quality of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Comprehensiveness of available services (health, behavioral health, and/or social services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Timeliness of services provided (health, behavioral health, and/or social services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Overall patient/client well-being	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Provision of culturally competent services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Disparities in access to care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Disparities in outcomes of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
l. Other WPC impact (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

3) Please indicate the extent to which the following have improved <u>as a result of participating in WPC</u>: If unknown, please select Unknown.

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
a. Extent to which WPC partners work together on collaborative projects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Extent to which WPC partners collect and share data to inform community needs assessment and program planning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Extent to which WPC partners collect and share data for program monitoring and feedback	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Extent to which WPC partners work together to pursue/ secure external funding	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Organizational innovation (e.g., innovation in service delivery and/or programs or in how your organization approaches delivers care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Your organization's awareness of service needs within the community	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. LE awareness of and access to inter-	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
departmental resources for county residents													
h. Other WPC impact (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 10: WPC Program Monitoring, Feedback, and Performance Improvement

The following questions ask about how your LE monitors metrics, feedback, and performance improvement related to the WPC program. Please answer each question in relation to WPC instead of what your organization might have been doing prior to WPC, unless specifically requested to do so.

1) Are you tracking any metrics (e.g., process measures and/or outcome data) other than the universal and variant metrics required by the California Department of Health Care Services (DHCS)? **[If no, skip to question 2]**

   ☐ Yes
   ☐ No

   1a. **[If yes],** please list these metrics and briefly describe your rationale for tracking these metrics (e.g., to monitor WPC partner progress in implementing WPC activities).

2) On average, how frequently are you collecting metrics related to WPC?

   ☐ Monthly (or more often)
   ☐ Quarterly
   ☐ Every 6 months
   ☐ Other (please specify _____)

3) In general, how is your LE using universal, variant, and/or other metrics being collected as part of the WPC pilot program? (Select all that apply)

   ☐ Track WPC partner progress in implementing WPC activities
   ☐ Inform quality improvement / performance improvement efforts

☐ Provide feedback on WPC processes and/or outcomes to partners
☐ Provide feedback on WPC processes and/or outcomes to frontline providers/staff responsible for delivering services to clients/patients
☐ Assess WPC impact on client/patient outcomes
☐ Compare outcomes across WPC partners

4) Please indicate the type(s) of individuals who have access to universal, variant, and/or other metrics being collected as part of the WPC pilot program. (Select all that apply)

☐ Senior leadership or administrative staff from my organization
☐ Senior leadership or administrative staff from WPC-participating Medi-Cal managed care plans
☐ Senior leadership or administrative staff from other WPC partners
☐ Clinical providers/staff providing WPC services
☐ Other providers and/or staff providing non-clinical WPC services
☐ Clients/patients or other lay members of the community
☐ Other (please specify: _____)
☐ Not applicable. We have not yet collected any of these data.

5) Prior to WPC, did your LE have experience implementing quality improvement activities in collaboration with WPC partners related to any of the following areas? (select all that apply)

☐ Coordination of health, behavioral health, and social services
☐ Sharing data
☐ Improving service access and/or outcomes for specific populations (e.g., high utilizers)
☐ Other (please specify: _____)
☐ No experience with QI activities in collaboration with WPC partners prior to WPC

6) On average, how often does your LE meet with WPC partners to discuss and/or implement quality improvement / performance improvement activities related to WPC?

☐ Never
☐ Weekly
☐ Monthly
☐ Quarterly
☐Every six months
☐ Annually

7) Please indicate the types of individuals most commonly involved in the quality improvement / performance improvement activities described above (select all that apply)

☐ Senior leadership or other administrative staff from my organization
☐ Senior leadership or administrative staff from WPC-participating Medi-Cal managed care plans
☐ Senior leadership or administrative staff from other WPC partners (not health plans)
☐ Clinical providers/staff providing WPC services
☐ Other providers and/or staff providing non-clinical WPC services
☐ Clients/patients or other lay members of the community
☐ Other (please specify: _____)
☐ Not applicable. We have not yet conducted any quality improvement/performance improvement activities for WPC

8) On a scale from 0 to 10, where 0=Not useful and 10=Very useful, how useful have you found these quality improvement activities in implementing WPC and/or improving WPC program outcomes?

0 = Not useful	**1**	**2**	**3**	**4**	**5 = Neutral**	**6**	**7**	**8**	**9**	**10 = Very useful**	**Comment**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 11: WPC Learning Collaborative

The following questions are about externally provided technical assistance and/or other supports provided by the California Health Care Safety Net Institute, DHCS/Harbage Consulting, etc in developing and/or implementing the WPC program.

1) On a scale from 0=Very low to 10=Very high, please indicate the usefulness of the following support activities in implementation of WPC in your organization:

	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
a. Sharing information with and learning from other WPC pilots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Technical assistance (e.g., one-on-one consulting, technical assistance related to legal issues, measurement issues, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

2) On a scale from 0 = Not effective to 10 = Extremely effective, please indicate which method of receiving technical assistance and/or other support for WPC pilot program activities was most effective/useful.

	0 = Not effective	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely effective	Comment
a. Webinars	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Websites or other online data repositories	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	0 = Not effective	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely effective	Comment
c. Web-based discussion forums	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Telephone meetings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. In-person meetings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Conclusion

1) Is there anything we haven't asked that you think is important for us to know? Please denote N/A if not applicable.

THANK YOU FOR COMPLETING THE SURVEY

Appendix O: Lead Entity and Frontline Staff Follow-up Interview Protocol

Lead Entity Follow-up Interview Protocol

Exhibit 1: Interview Protocol with Lead Entity Leadership

1. **Introduction of UCLA team members**. "Hi, my name is ___ and these are my colleague(s) _____. He/she/They are with me today to help ensure I cover all the bases and to take notes. Thank you for taking the time to speak with us today. "
2. **Broad evaluation goals**. "Before we begin, let me review some general information. This interview is being conducted as part of our evaluation of the Whole Person Care demonstration projects and is designed to supplement information already being provided in your annual and semi-annual reports. We will ask questions about your overall assessment of the program, program changes, and lessons learned. Combined with your responses to the survey you recently completed, we hope to gain a deeper understanding of the program and to be able to provide a fair and comprehensive representation of this program statewide to DHCS and CMS."
3. **Interview format**: "We expect the interview to last approximately X minutes. [adjust as appropriate] This interview is voluntary, and you are free to skip questions or stop or postpone the interview at any time."
4. **Privacy**: "To protect privacy, throughout this interview it will be helpful if you can refer to your colleagues by title or role rather than name. If you forget and use names that is okay; we will redact names later."
5. **Permissions.** "Because we value everything you have to say and want to make certain we don't miss anything, we would like to audio-record this interview. Is this okay with you? Only project staff will hear the recording and it will stay password protected on secure computers. Recordings will be transcribed, analyzed, and summarized. Your name will not be used in interview paperwork or in any final reports or publications. Instead, each participant receives a unique ID number that is used in place of your name or other identifying information. The recording is purely for our internal purposes. If you are not comfortable being recorded, we can take written notes instead."

   [If Yes] Thank you. I will now turn on the recorder and re-ask this question of you to record your oral permission to record. [Turn on Recorder] This interview is being recorded. I am asking your oral permission to be recorded. Do you grant me your

permission to record this interview session? [pause for "Yes" answer] As stated before in our earlier conversation, you can ask me to pause or turn off the recorder at any time.

[If No] OK, I will not be recording this session but only taking notes of our conversation.

[If recording] This is code number XXXXXX, and the date is XXXXXXX.

Introduction

1. Can you tell me a little bit about your role in [name of WPC project at their county]?
2. How long have you been in this role?

Motivation for Participating in WPC

3. Can you tell me a little bit about your organization's **primary** motivation for participating in WPC? [top-of-mind motivations]
4. How does WPC fit in with your organization's overall strategic priorities? Would you rate WPC as a high, medium, or low priority for your organization? Why?
5. Can you tell us briefly about how the WPC pilot program was developed in your county? For example, how did you decide who to partner with on this initiative? What factors affected your decision to focus on specific target population(s) or services to offer?

Other Programs or Initiatives

In your response on the survey, you indicated that your organization was participating in other initiatives similar to WPC (for example, in terms of program goals, target populations being served, services being delivered, etc.)?

6. Can you tell us a little bit about these other initiatives?
7. To what extent are there synergies with the WPC program and these other initiatives? [focus on projects with high levels of synergy, understand implications for implementation and sustainability of WPC]
8. Can you talk a little bit about any challenges with ensuring non-duplication and/or non-overlap between the WPC program and these other initiatives? (Examples of other initiatives: Health Homes, Full Service Partnerships, PRIME)

WPC Program Overview and Program Changes

Now I'd like to ask a few questions about how WPC is being implemented in your county.

9. In the survey, you indicated XX changes to original WPC plans. Can you tell me a little bit more about modifications/adjustments/adaptations made to original plans for WPC? For example, any changes in eligibility criteria for WPC or to how target population(s) are defined? What about to WPC programs or services being provided? What changes or adjustments were made, and why?

We realize that in some cases, LEs are expanding existing programs and in others, you are developing entirely new programs from the ground-up.

10. Can you confirm this list accurately reflects the specific programs/services you are providing under WPC?
11. For each of these programs, can you tell us whether it is a completely new program or an expansion of an existing program (e.g., to serve new target populations, etc.)? For expansions of existing programs, can you speak a little bit to how much of a change to the existing program was made (e.g., requiring significant changes to existing policies and practices vs. minimal change)?
12. For each of these programs, can you also confirm whether services are provided on a FFS basis or PMPM?
13. In your responses to the [LE/partner] survey, you indicated needing to make significant changes to organizational policies and practices in order to implement WPC. Can you provide example(s) of the types of changes your organization had to make in order to implement WPC program(s)/activities?
14. In your responses to the [LE/partner] survey, you indicated a high level of effort for [X, Y, and Z]. Could you please provide additional context to help us understand the type of effort involved? [If all elements are high scoring: probe distinctions across elements for better understanding; comparative statements as appropriate]

Infrastructure and Resources

Next, I'd like to ask a few questions about the infrastructure your LE had in place related to data sharing and care coordination before and after WPC. [*Note: Please review cheat sheet]*

15. Our data suggest that you are implementing XX as part of WPC, and that YY were in place prior to WPC. Can you please elaborate on any changes made specifically to support WPC efforts?
16. In the LE questionnaire you indicated [X, Y, and Z] as existing infrastructure related to care coordination in place prior to WPC — could you please elaborate on any changes made specifically to support WPC efforts?

Care Coordination

Because WPC is fundamentally about improved coordination and/or integration of care, we'd like to be sure we understand how care coordination works in your WPC program.

Examples:

17. In your application, narrative report to DHCS, and/or in the survey, you indicated that you were planning to implement X. Can you tell us a little bit about how that process has been going? Any major lessons learned? Any major changes?
18. *Plans, rules, agreements:* Can you tell me a little bit about any formal rules, policies, procedures in place for defining LE and partner responsibilities for different tasks? For example, any MOUs, BAAs, or other contracts you've established specifically for WPC?
19. *Data and/or other technology and tools:* In your application, you indicated that you were planning to implement [X data sharing, technology, or tool]. Can you tell me a little bit about how that process is going? Have you implemented or plan to implement any other technology or tools to help facilitate sharing of information across teams or partner organizations? For example, are there standard referral protocols or pathways in place that staff are asked to follow?
20. *Roles:* In your application, it sounds like [staff role] will be responsible for coordinating care for eligible beneficiaries. Can you tell me a little bit more about how that process works? Have you developed any other new roles/positions to assist with care coordination? We are finding considerable heterogeneity across WPC sites in the type of staff responsible for care coordination. Can you talk a little bit about the factors that led to the decision to use [staff role] over another type of role, such as XXX? What do you perceive as the primary pros and cons of using [staff role] for care coordination?
21. *Proximity:* We realize there are significant differences across LEs in terms of whether staff involved in WPC are co-located vs. meeting regularly face-to-face vs. communicating only via sharing of electronic information. Can you speak a little bit to how staff responsible for care coordination typically communicate, and using what medium? [Probe: care coordinator communications, care coordinator with other staff, etc.]
22. Would you be willing to share copies of any (non-proprietary) materials that would help the UCLA evaluation team better understand how care coordination works in your WPC pilot? (e.g., copies of any referral protocols, flowcharts, etc.)
23. **Can you tell me a little bit about the process for hiring [staff responsible for care coordination]?** What does the training process look like? What about supervision? What type(s) of opportunities for professional development / continued education/

additional training do these staff have access to? What supports are available to staff if they have questions about their work [e.g., issues with patients/clients, questions about available resources, etc.]?

24. Can you tell me a little bit about the staff performance review process? How does that work?
25. Who do [staff responsible for care coordination] report to? What outcomes are [staff responsible for care coordination] accountable for meeting?
26. Can you speak to any major lessons learned in terms of coordinating or integrating care for target populations as part of WPC? (e.g., advice you might give to other counties interested in implementing this type of initiative).

Health Information Exchange

27. Is participation in an HIE planned as part of WPC implementation?
28. Could you please provide a broad overview of how the HIE is used for WPC implementation (information shared/accessed, by whom, etc.)? Have any aspects of your HIE changed as a result of WPC?

Partnerships

29. We know that WPC relies heavily on partnerships. We appreciate the updated partner lists and classifications provided. We saw that you removed X partners and added Y partners. Can you tell us a little bit about why these changes occurred?
30. Can you tell us a little bit more about the partnerships that have developed as a result of WPC? For example, how did you decide which partnerships to pursue? How easy/difficult to develop partnerships for WPC?
31. What challenges have you encountered in coordinating or otherwise integrating WPC activities with partner organizations?
32. What strategies have you found successful at breaking down siloes between partners, particularly internal partners (e.g., other county agencies, or departments within same umbrella agency)?
33. Have you noticed any significant changes in the extent to which WPC partners work together on collaborative projects as a result of WPC? Why or why not? Can you provide an example?
34. Are there any "gaps" in terms of partnerships needed to successfully coordinate or integrate care for certain target populations?

Identifying, enrolling, and/or engaging beneficiaries

Next, we'd like to ask a few questions about your process for identifying, enrolling, and/or engaging beneficiaries in WPC. Some of these questions will be broad ("big picture") and some will be specific to better understanding how these processes are reflected in the enrollment and utilization reports you are submitting to DHCS.

35. Can you speak a little bit to your experience identifying, recruiting, and/or retaining eligible enrollees in WPC programs? Which specific strategies have you found most effective at promoting engagement by eligible patients/clients? What have you found most challenging about this process?
36. [If applicable] In your LE questionnaire you indicated you have an opt-in enrollment program. Can you provide a little bit more information about your process for identifying, engaging, and consenting eligible enrollees?
    - At what point in the process is an enrollee's enrollment status marked as "yes?"
    - What are the major challenges to the opt-in structure?
37. [If applicable] In your LE questionnaire you indicated you have an opt-out enrollment program. Can you provide a little bit more information about your process for identifying, engaging, and consenting eligible enrollees?
    - What services, if any, are provide before getting consent?

Enrollment and utilization data

38. Are you tracking the target populations and homeless status of enrollees in the enrollment/utilization reports?
    - You have currently only used [List of Target Pops used in reports]. Why have you used these and not the others?
    - What is your process for determining enrollee's designations in these groups?
    - Can an enrollee's designation change at any point? If they secure housing, would their homeless status change?
39. How is disenrollment handled in your pilot?
    - What systems are in place to promote graduation from the pilot?
    - How is disenrollment information collected?
        - When is an enrollee disenrolled for "Lack of Engagement?"
        - Who is responsible for tracking data and selecting the disenrollment reason?
40. What challenges have you faced in completing the enrollment and utilization reports? Has the format of the report prevented you from being able to accurately describe your pilot's enrollment, enrollment patterns and utilization?

WPC or WPC-Like Services for non-WPC patients/clients

We realize WPC programs were developed with specific target populations in mind. However, we are also curious about other populations that may benefit from WPC or WPC-"like" services.

41. Are WPC program(s)/services only available to WPC-eligible beneficiaries or can other patients/clients access them as well? E.g., what happens if you identify a high-utilizing patient/client who could benefit from WPC services but is uninsured or ineligible, or a Medi-Cal beneficiary who doesn't meet all WPC eligibility criteria but could still benefit from WPC services? If these services are available to other patients/clients, how are these services funded?

Flexible Housing Pool (optional/lower priority)

42. We noticed in your application that you are using a Flexible Housing Pool to help support access to housing for target population(s). Can you tell us a little bit about how the housing pool works and how it's funded?

Major Milestones

43. In your annual narrative report, you provided an update regarding the status of your program. Of the different milestones achieved, what do you feel is the most significant? Why?

Critical Success Factors and Lessons Learned

44. What do you view as the critical success factors affecting whether targeted WPC outcomes/program benefits are realized?
45. Do you have any advice for other counties or states considering whether to adopt similar program(s) (e.g., regarding best practices, major lessons learned, etc.)?

WPC Impact

Next, I'd like to ask a few questions focused specifically about perceived impact of WPC in your community.

Examples:

46. If indicate significant changes in organizational innovation, probe for examples

47. Has your organization been able to use WPC to leverage additional funding or other resources? (If yes, please describe)
48. Other than direct funding of programs, can you speak to any additional benefits of WPC funding in your ability to implement the program?
49. Could you speak to overall impact and value of WPC to your LE/county?

Evaluation, Reporting and Quality Improvement Activities

50. Can you tell us a little bit about any internal evaluation activities you are engaged in related to WPC? What question(s) are you hoping to answer with the internal evaluation?
51. What question(s) if any do you hope the UCLA evaluation will help address?
52. Is your organization tracking any additional metrics other than the required universal and variant metrics? If yes, can you speak to the rationale for tracking these metrics / how these data will be used?

Technical Assistance

53. Can you tell me a little bit about any externally provided technical assistance or support you've found particularly useful in developing and/or implementing WPC pilot program(s)?
54. Are there any other supports you wish you had or would find useful?

WPC Sustainability

Finally, we realize this is a bit early, but wanted to ask a few questions related to potential sustainability of WPC infrastructure and activities.

55. What factor(s) will your organization consider in deciding whether to sustain WPC program component(s) after funding ends?
56. Which WPC program component(s) are likely to be sustained after WPC funding is over? Why or why not?
57. What strategies (if any) has your organization considered for continuing to fund WPC activities after 2020? (e.g., Health Homes, community development financial institutions, etc.)

Conclusion

58. Is there anything we haven't asked at this point that you think would be important for us to know?

Frontline Staff Follow-up Interview Protocol

Exhibit 2: Interview Protocol with Frontline Staff

1. **Introduction of UCLA team members**. "Hi, my name is ___ and these are my colleague(s) _____. He/she/They are with me today to help ensure I cover all the bases and to take notes. Thank you for taking the time to speak with us today. "
2. **Broad evaluation goals**. "Before we begin, let me review some general information. This interview is being conducted as part of our evaluation of the Whole Person Care demonstration projects. We will ask questions about your current work experiences and training, your perceptions of the program and its impact on participants, and any challenges or lessons learned."
3. **Privacy**: "To protect privacy, throughout this interview it will be helpful if you can refer to your colleagues by title or role rather than name. If you forget and use names that is okay; we will redact names later."
4. **Interview format**: "We expect the interview to last approximately one hour and 30 minutes. [adjust as appropriate] This interview is voluntary, and you are free to skip questions or stop or postpone the interview at any time."
5. **Permissions.** "Because we value everything you have to say and want to make certain we don't miss anything, we would like to audio-record this interview. Is this okay with you? Only project staff will hear the recording and it will stay password protected on secure computers. Recordings will be transcribed, analyzed, and summarized. Your name will not be used in interview paperwork or in any final reports or publications. Instead, each participant receives a unique ID number that is used in place of your name or other identifying information. The recording is purely for our internal purposes. If you are not comfortable being recorded, we can take written notes instead."

   [If Yes] Thank you. I will now turn on the recorder and re-ask this question of you to record your oral permission to record. [Turn on Recorder] This interview is being recorded. I am asking your oral permission to be recorded. Do you grant me your permission to record this interview session? [pause for "Yes" answer] As stated before in our earlier conversation, you can ask me to pause or turn off the recorder at any time.

   [If No] OK, I will not be recording this session but only taking notes of our conversation.

   [If recording] This is code number XXXXXX, and the date is XXXXXXX.

Introduction

1. Can you tell me a little bit about yourself and your role in [name of program]?

- How long have you been in this role?

Care coordinator role

Because WPC is fundamentally about improved coordination and/or integration of care, we'd like to be sure we understand how care coordination works in your WPC program. **Can you describe what care coordination means to you and your organization? How does your organization define care coordination?**

Can you start by telling me a little bit more about what these support teams look like, and about how responsibility for care coordination is distributed across teams? (e.g., is it principally the responsibility of the medical social worker)? Have you developed any other new roles/positions to assist with care coordination? **We are finding considerable heterogeneity across WPC sites in the type of staff responsible for care coordination. Can you talk a little bit about the factors that led to the decision to use [staff role] over another type of role, such as XXX? What do you perceive as the primary pros and cons of using [staff role] for care coordination?**

2. How would you describe your job to someone who knew nothing about it?
   - What is a typical day like for you working here?
   - (If applicable) What is your typical caseload like?

3. Who else do you typically work with in a given day or week?
   - If you are part of a team, can you tell me a little bit about how that team is structured and staffed?
   - How are responsibilities typically distributed across the team?
   - When you need to communicate with team members about daily tasks or patients/clients, how does that typically happen?

4. What do you see as the skills a person needs to do your job well? What makes a good (name their role)?

5. What do you like best about your work?

6. How much flexibility do you have in the way you approach your work? (e.g., Are there fairly structured steps you have to follow in your daily work with patients or clients?)

7. What are the biggest challenges you face in your current role?

Identifying, enrolling, and/or engaging eligible beneficiaries

Next, I'd like to ask a few questions about the patients or clients you work with.

8. How are potential patients or clients identified?
    - (If applicable) Who are the primary community partners you receive referrals from?

9. In general, what happens after eligible patients or clients are identified or referred to your program?

10. How difficult is it to engage patients or clients?
    - (If applicable) What does the enrollment process typically look like?
    - Any strategies you have found particularly successful for engaging patients or clients?

11. Can you tell me a little bit about what happens after patients/clients are enrolled in the program?
    - How frequently do you meet with patients/clients once they are enrolled in the program?
    - How do you typically communicate with patients or clients?
    - What types of services do they receive, and from where?
    - How is care typically coordinated with other providers?
    - (if not previously addressed) How do you typically communicate with other members of the team and/or with other service providers?
    - What types of barriers (if any) have you encountered in coordinating care for eligible patients or clients?
    - What strategies have you found most effective for coordinating care with other providers?

12. How long do patients or clients typically receive services from your program?
    - When/why do patients or clients typically leave the program?
    - Can you tell me a little bit about what the disenrollment process is like?
    - How often do patients or clients "re-enroll"?

13. Are you required to track any information about patients or clients that have been referred, enrolled, and/or otherwise engaged with your program?
    - What type of information are you required to collect?
    - How is that information collected?
    - Who sees that information?
    - Do you find this information useful in informing your work?

Training and/or technical assistance

I'd also like to learn a little bit about any training you received to prepare you for this role.

14. Can you tell me a little bit about what the initial orientation process was like?
    - What type of training did you receive to prepare you for your current role?
    - How helpful have you found this training?

15. Can you tell me about any supports the county has in place to help with your daily work? For example, resources you can draw on if you have questions or concerns about your daily work, technology or tools that make it easier to share information with other members of the team, other providers, and/or with the patients or clients you work with.
    - How useful do you find these supports? Why or why not?
    - How often do you use these supports?
    - Are there any other supports or resources you wish you had access to? Why or why not?

16. Have you been involved in any quality improvement efforts related to your program?

Perspectives on the program

17. What do you view as the greatest strength of [name of program respondent works for]?

18. If you could change *one* thing about the WPC program, what would it be? [Ideal world]

19. Do you have any advice or major lessons learned to share with others that might be interested in putting together a program like yours?

Conclusion

20. Is there anything I haven't asked that is important for us to know?

Appendix P: Partner Survey Instrument

Introduction and Instructions

The UCLA Center for Health Policy Research was selected by California Department of Health Care Services to evaluate the Whole Person Care (WPC) pilot program. As part of the evaluation, we are administering questionnaires to participating Lead Entities (LEs) and key partners to gather more information about different partners' perceptions of WPC, communication and collaboration among WPC partners, and changes that have occurred as a result of participating in WPC. Questions in this survey are focused on specific issues that are not clearly or consistently reported by LEs in their mid-year and annual reports to DHCS.

This questionnaire is to be completed by individuals most knowledgeable about the WPC program within your organization, and may include more than one person. We are interested in **your organization's perspective** on these questions; LE perspectives are assessed via a separate survey.

The PDF or word document version of this questionnaire can be used by all respondents to determine appropriate answers; however, due to limitations of our online data system (SurveyMonkey) we ask that all responses be entered online by one individual in your organization.

For ease, please enable cookies on your browser. With cookies enabled, responses will be saved prior to submission of the questionnaire as long as the respondent uses the same computer and browser.

Average time to complete this questionnaire will vary but is expected to be 45 minutes to an hour.

Confidentiality. Your responses will be kept confidential. No one outside the UCLA evaluation team, including LEs, other WPC partners, or DHCS will have access to your individual responses. Only aggregated data will be included in evaluation reports and publications. **Participation in the survey will not affect your organization's relationship with your WPC LE or the LE's funding from DHCS**.

The evaluation team are available to answer your questions if needed. Please contact the UCLA evaluation team at wpc@chpr.em.ucla.edu with questions.

Domain 1. Respondent Information

1. Your Organization's Name _____

2. Your Role within the Organization _____

3. Approximately how many FTEs does your organization have? _____

4. LEs are partnering with many different types of organizations. Please indicate your organization type. (Select all that apply).
   - ☐ County mental health agency
   - ☐ County substance abuse treatment agency
   - ☐ County housing agency
   - ☐ Probation / law enforcement
   - ☐ Other public agency (please specify ____)
   - ☐ Health plan
   - ☐ Hospital
   - ☐ Community clinic or clinic network
   - ☐ Private mental health or substance abuse treatment agency
   - ☐ Private human services / social services provider (e.g., legal aid, housing, etc.)
   - ☐ Other community provider (please specify _____)

5. Is your organization partnering with more than one WPC Lead Entity (LE)? **[If no, skip to question 6]** ☐ Yes ☐ No
   5a. **[If yes]** Please specify which WPC pilot program(s) you are working with (Select all that apply).
   - ☐ Alameda County Health Care Services Agency
   - ☐ City of Sacramento
   - ☐ Contra Costa Health Services
   - ☐ County of Marin, Department of Health and Human Services

☐ County of Orange, Health Care Agency
☐ County of San Diego, Health and Human Services Agency
☐ County of Santa Cruz, Health Services Agency
☐ County of Sonoma, Department of Health Services Behavioral Health Division
☐ Kern Medical Center
☐ Kings County Human Services Agency
☐ Los Angeles County Department of Health Services
☐ Mendocino County Health and Human Services Agency
☐ Monterey County Health Department
☐ Napa County
☐ Placer County Health and Human Services Department
☐ Riverside University Health System Behavioral Health
☐ San Bernardino County Arrowhead Regional Medical Center
☐ San Francisco Department of Public Health
☐ San Joaquin County Health Care Services Agency
☐ San Mateo County Health System
☐ Santa Clara Valley Health and Hospital System
☐ Small County Whole Person Care Collaborative
☐ Shasta County Health and Human Services Agency
☐ Solano County Health and Social Services
☐ Ventura County Health Care Agency

6. Please indicate the ways in which your organization is involved in WPC: (Select all that apply)

☐ Helped develop the original WPC pilot program application
☐ Member of steering committee / leadership committee responsible for project management and oversight
☐ Member of other committees or workgroups that meet regularly to discuss WPC implementation
☐ Share your data with the LE or other WPC partners for community needs assessment and/or program planning (e.g., identify potential gaps in care, prioritize resources, etc.)

☐ Share data regarding WPC program results / outcomes with the LE or other WPC partners
☐ Share your data with other WPC partners (not including LE) to identify eligible clients/patients eligible for WPC
☐ Share your data with the LE or other WPC partners to facilitate case management and/or coordination of care for WPC enrollees
☐ Shared clientele with WPC
☐ Identify and refer eligible patient/clients for WPC enrollment
☐ Receive referrals from LE and/or other organizations participating in WPC
☐ Deliver clinical services to WPC enrollees
☐ Deliver non-clinical services to WPC enrollees
☐ Provide case management and/or care for WPC enrollees
☐ Other (please specify _____)

7. How often do you or other members of your organization participate in meetings involving the WPC program? **[If Never, skip to Domain 2]**
   ☐ Never
   ☐ Weekly
   ☐ Biweekly
   ☐ Monthly
   ☐ Quarterly
   ☐ Twice a Year
   ☐ Annually
   ☐ Other (please specify _____)

8a. Who typically participates in meetings you attend that involve the WPC program? (Select all that apply)
   ☐ Lead entity
   ☐ Representatives from Medi-Cal managed care plans
   ☐ Representatives from health care agencies
   ☐ Representatives from behavioral health care agencies
   ☐ Representatives from housing or homeless support service providers

☐ Other WPC partners
☐ Eligible clients/patients or other lay members of the community
☐ Other (please specify ____)

8b. What is the purpose of these meetings? (Check all that apply)

☐ WPC program planning and implementation
☐ WPC program enrollment
☐ WPC program performance
☐ Data use and sharing
☐ Coordinate or otherwise integrate activities with WPC partners
☐ Communications and/or marketing
☐ Other (please specify _____)

Domain 2. Motivation for WPC

The following questions are about **your organization's** motivation to participate in the WPC program and how WPC fits with **your organization's** mission and overall strategic goals.

2) Please rate on a scale of 0 to 10, where 0=Not at all important and 10=Very important, the importance of the following factors to your organization's decision to participate in the WPC program. If a particular element is not applicable, please select N/A and explain in the comment section.

	N/A	0 = Not at all important	1	2	3	4	5 = Neither important nor unimportant	6	7	8	9	10 = Very important	Comment
a. Synergy with other existing or planned programs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Consistency with organizational goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Improve coordination or integration of care for clients/patients with multiple needs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Develop collaborative relationships with other participating WPC entities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Continue/maintain collaborative relationships with other participating WPC entities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Not at all important	1	2	3	4	5 = Neither important nor unimportant	6	7	8	9	10 = Very important	Comment
f. Access additional services for current patients/clients	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Receive patient/client referrals from other participating WPC entities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Access to new patients/clients with whom my organization has previously had little contact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Ease of implementation (e.g., due to concordance of WPC activities with existing processes of care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Low resource requirements (e.g., lowest cost, least staff time to implement)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Reduce cost of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
l. Improve quality of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
m. Obtain funding for my organization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
n. Other (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 3. WPC Implementation

The questions in this section asks about implementation of the core components of WPC (as outlined in Attachment HH to the WPC Special Terms and Conditions) and overall implementation strategies. Please answer each question from the perspective of **your organization**.

8) Please rate the overall level of effort required **of your organization** to implement the following WPC program activities on a scale where
0 =Very low to 10 =Very high. If you are not engaged in a specific activity, please select N/A

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
a. WPC data governance (i.e., management of data being shared as part of WPC)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Other WPC program governance (e.g., participation in committee meetings)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Recruiting or hiring providers/staff to deliver WPC services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Ensuring sufficient physical space and/or other administrative infrastructure necessary to implement WPC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Executing Data Use Agreements (DUA) or Business Associate Agreements (BAAs) with LE and/or other WPC partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A	0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
f. Data sharing with LE and/or other WPC partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Coordinating or integrating WPC activities with health plan partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Delivering WPC services (e.g., case management, housing navigation and tenancy support, linkage to re-entry, substance use disorder or mental health treatment, or other support services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Identifying eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Engaging eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Meeting WPC reporting requirements and timelines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

9) On a scale from 0 to 10 where 0=Very low and 10=Very high, please rate the extent to which leadership turnover and/or other changes to leadership within your organization has posed challenges to implementing WPC?

0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

10) On a scale from 0 to 10 where 0=Very low and 10=Very high, please rate the extent to which staff turnover and/or other staffing changes within your organization has posed challenges to implementing WPC?

0 = Very low	1	2	3	4	5 = Neither low nor high	6	7	8	9	10 = Very high	Comment
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 4. WPC Leadership, Communication, and Decision-Making Processes

The questions in this section ask about WPC collaborative leadership, communication and decision-making processes. The entities that comprise the WPC's leadership were defined in your WPC application. Please answer each question from the perspective of **your organization**.

2) To what extent do you agree / disagree with the following statements about WPC leadership, communication, and decision-making processes. If unknown, please select Unknown.

	Unknown	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Comment
a. All participating WPC partners are involved in discussion about WPC.	☐	☐	☐	☐	☐	☐	
b. WPC leadership team has clear and explicit procedures for making important decisions	☐	☐	☐	☐	☐	☐	
c. WPC decision-makers share ideas and information with partners	☐	☐	☐	☐	☐	☐	
d. WPC partners willingly collaborate and cooperate with each other	☐	☐	☐	☐	☐	☐	
e. My organization is informed as often as it should be about what is happening in WPC.	☐	☐	☐	☐	☐	☐	
f. Communication among WPC LE and partners happens both at formal meetings and informally	☐	☐	☐	☐	☐	☐	
g. WPC partners have a clear sense of their roles and responsibilities in relation to the program	☐	☐	☐	☐	☐	☐	
a. All WPC partners have a clear and shared vision of how to achieve WPC program outcomes	☐	☐	☐	☐	☐	☐	

	Unknown	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Comment
b. All WPC partners are in agreement about WPC priorities	☐	☐	☐	☐	☐	☐	
c. All WPC partners are in agreement about the best strategies to pursue to achieve WPC priorities	☐	☐	☐	☐	☐	☐	
a. WPC leadership team is effective at keeping all WPC partners focused on tasks and objectives	☐	☐	☐	☐	☐	☐	
b. WPC leadership team is skillful at resolving conflicts between WPC partners	☐	☐	☐	☐	☐	☐	
a. The WPC partners represent all types of organizations and/or sectors of the community needed to successfully achieve program goals.	☐	☐	☐	☐	☐	☐	
b. The WPC partners represent an appropriate cross-section of those who have a stake in the goals of WPC.	☐	☐	☐	☐	☐	☐	
c. The level of commitment among all WPC partners is high.	☐	☐	☐	☐	☐	☐	
a. We are able to keep up with all the work necessary to implement WPC.	☐	☐	☐	☐	☐	☐	
My organization has had significant influence in the following WPC activities:							
a. Defining partner roles and responsibilities	☐	☐	☐	☐	☐	☐	
b. Customizing/adapting WPC goals to fit the needs of the local community	☐	☐	☐	☐	☐	☐	

	Unknown	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Comment
c. Determining how WPC funding will be allocated to ensure completion of WPC activities	☐	☐	☐	☐	☐	☐	
d. Determining how WPC services will be delivered to clients/patients	☐	☐	☐	☐	☐	☐	
a. WPC enrollees are a small portion of my organization's clients/patients	☐	☐	☐	☐	☐	☐	
b. WPC enrollees use a disproportionate level of resources compared with the rest of my organization's clients/patients	☐	☐	☐	☐	☐	☐	
c. Currently available funding is not sufficient to cover organizational costs of implementing all WPC activities.	☐	☐	☐	☐	☐	☐	

Domain 5. Inter-agency Collaboration

The following questions address inter-agency collaboration and interactions with WPC partners, specifically in regards to how those relationships changed over the course of the WPC implementation.

3) Please indicate the ways in which *your organization* interacted with each of the following WPC partners PRIOR to WPC.

Partner organizations	None / no prior interaction	Planning	Administration	Service Delivery			Other (please specify in comments including partner name)
		Joint advocacy or joint planning (e.g., as part of a community coalition)	Data sharing (e.g., for client/patient care, needs assessment)	Client/patient referrals	Communication about client/patient needs and/or care	Joint service delivery (e.g., you deliver part of a service and contract for the rest)	
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Partner organizations	None / no prior interaction	Planning	Administration	Service Delivery			Other (please specify in comments including partner name)
		Joint advocacy or joint planning (e.g., as part of a community coalition)	Data sharing (e.g., for client/patient care, needs assessment)	Client/patient referrals	Communication about client/patient needs and/or care	Joint service delivery (e.g., you deliver part of a service and contract for the rest)	
	☐	☐	☐	☐	☐	☐	☐

Comment(s):

4) Please indicate the ways in which *your organization* CURRENTLY interacts with each of the following WPC partners:

Partner organizations	None / no interaction	Planning	Administration	Service Delivery			Other (please specify in comments including partner name)
		Joint advocacy or joint planning (e.g., as part of a community coalition)	Data sharing (e.g., for client/patient care, needs assessment)	Client/patient referrals	Communication about client/patient needs and/or care	Joint service delivery (e.g., you deliver part of a service and contract for the rest)	
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Comment(s):

Domain 6. Perceived Impact of WPC

The questions in this section ask about the perceived impact of WPC thus far (e.g., in achieving programmatic goals, improving care for clients/patients, and/or improving other organizational outcomes). Please answer each question from the perspective of **your organization**.

4) On a scale from 0 to 10, where 0=Not effective and 10=Extremely effective, please indicate how effective the WPC program has been thus far at achieving the following goals. If unknown or not perceived to be a goal of the WPC program, please select Unknown.

	Unknown	0 = Not effective	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely effective	Comment
a. Manage the care of high risk and high utilizing populations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Earlier identification of client/patient needs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Improve identification of clients/patients receiving services from more than 1 system	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Improve coordination of health, behavioral health and social services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Increased data sharing with LE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Increase client/patient access to housing and supportive services (e.g., housing navigation, tenancy support)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Increase client/patient access to other social	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Unknown	0 = Not effective	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely effective	Comment
services (e.g., employment assistance, TANF, etc.)													
h. Increase client/patient access to mental health and/or substance abuse treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

5) Please indicate the extent to which the following areas have improved for your organization's clients/patients as a result of participating in WPC. If unknown, please select Unknown.

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
a. Coordination of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Continuity of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Access to needed services (health, behavioral health, and/or social services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Access to affordable housing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Quality of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Comprehensiveness of available services (health, behavioral health, and/or social services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Timeliness of services provided (health, behavioral health, and/or social services)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Overall patient/client well-being	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Provision of culturally competent services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
j. Disparities in access to care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Disparities in outcomes of care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
l. Other WPC impact (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

6) Please indicate the extent to which the following have improved as a result of participating in WPC. If unknown, please select Unknown.

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
a. Extent to which WPC partners work together on collaborative projects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Extent to which WPC partners collect and share data to inform community needs assessment and program planning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Extent to which WPC partners collect and share data for program monitoring and feedback	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Extent to which WPC partners work together to pursue/ secure external funding	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Organizational innovation (e.g., innovation in service delivery and/or programs or in how your organization approaches delivers care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Unknown	0 = Not at all	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very much	Comment
f. Your organization's awareness of service needs within the community	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Other WPC impact (please specify _____)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 7: Identifying and Retaining Eligible Beneficiaries

This section addresses questions on how target populations and eligible beneficiaries are identified and retained for the WPC program. Please answer each question from the perspective of **your organization** only.

1) Participation in WPC programs is voluntary. On a scale from 0 to 10 where 0=Not difficult and 10=Extremely difficult, please indicate how difficult it has been to identify, recruit and/or retain eligible beneficiaries in WPC program(s)? (Select N/A if your organization is not involved in this activity as part of WPC and provide explanation in the comment).

	N/A	0 = Not difficult	1	2	3	4	5 = Neutral	6	7	8	9	10 = Extremely difficult	Comment
a. Identifying eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Recruiting eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Retaining eligible beneficiaries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Domain 8. WPC Program Monitoring, Feedback, and Performance Improvement

The following questions ask about how **your organization** monitors metrics, feedback, and performance improvement related to the WPC program. Please answer each question in relation to WPC instead of what **your organization** might have been doing prior to WPC, unless specifically requested to do so.

9) On average, how often does your organization meet with the Lead Entity (LE) and/or other WPC partners to implement quality improvement / performance improvement activities related to WPC? **[If Never, skip to Question 2]**

☐ Never
☐ Weekly
☐ Monthly
☐ Quarterly
☐ Twice a Year
☐ Annually

1a. On a scale from 0 to 10 where 0=Not helpful and 10=Very helpful, please indicate how helpful you have found these quality improvement activities in improving WPC program implementation or outcomes.

0 = Not helpful	1	2	3	4	5 = Neutral	6	7	8	9	10 = Very helpful	Comment
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

10) On average, how often do you or other representatives from your organization receive feedback regarding your organization's participation in WPC?

☐ Never
☐ Weekly
☐ Monthly

☐ Quarterly
☐ Annually

11) On average, how often do you or other representatives from your organization receive information regarding overall WPC pilot program outcomes? (e.g., total number of eligible patients/clients enrolled, performance on metrics being collected, etc.)

☐ Never
☐ Weekly
☐ Monthly
☐ Quarterly
☐ Annually

Conclusion

1) Please identify up to 3 challenges, in order of importance, that you encountered while planning and implementing WPC and up to 3 promising strategies that were used to or could be used to address these challenges. If you have not encountered challenges, please write N/A in Comments.

Challenges	Promising Strategies	Comment
1.	1.	
2.	2.	
3.	3.	

2) Do you have any recommendations for how the WPC program could be improved?

3) Is there anything we haven't asked that you think is important for us to know?

THANK YOU FOR COMPLETING THE SURVEY!

Appendix Q: General Glossary

Exhibit 1 defines acronyms and terms referenced throughout the report.

Exhibit 1: Acronyms and Definitions

Acronym	Definition
WPC	Whole Person Care
ACR	All-Cause Readmissions
AHRQ	Agency for Healthcare Research and Quality
AHS	Alameda Health System
AMB	Ambulatory Care
AMB-ED	Ambulatory Care – Emergency Department
AOD	Alcohol and other drugs
ASAC	Adult System and Care
BAA	Business Associate Agreement
BH	Behavioral Health
BP	Blood Pressure
CAPH	California Association of Public Hospitals and Health Systems
CBO	Community based organization
CBP	Controlling Blood Pressure
CBP-18-59	Enrollees 18-59 years of age whose BP was <140/90 mm Hg
CBP-60-85-D	Enrollees 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg

CBP-60-85-ND	Enrollees 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
CCP	Comprehensive Care Plan
CCW	Chronic Conditions Data Workhouse
CCMS	Coordinated Care Management System
CCP	Comprehensive Care Plan
CCP-A	Comprehensive care plan within enrollees' anniversary of enrollment
CCP-E	Comprehensive care plan within 30 days of enrollment
CDC	Community Development Commission
CDC	Comprehensive Diabetes Care
CE	Coordinated Entry
CEOs	Chief Executive Officer
CFR	Code of Federal Regulations
CHEAC	County Health Executives Association of California
CHW	Community health workers
CMS	Centers for Medicare & Medicaid Services
CoC	Continuum of Care
COPD	Chronic Obstructive Pulmonary Disease
DD	Difference-in-Difference
DHS	Department of Health Services
DHCS	California Department of Health Care Services
DJI	Decrease Jail Incarcerations

DSRIP	Delivery System Reform Incentive Payments
DTI	Dental Transformation Initiative
DUA	Data Use Agreements
ED	Emergency department
EHR	Electronic health record
EHS	Electronic Health System
EMS	Emergency Medical Services
Ems6	Emergency Medical Services in San Francisco, also known as HEART
ENS	Engagement, Navigation, and Support
EO	Eligibility Operations
FFS	Fee-for-Service
FSP	Full Service Partnership
FQHC	Federally Qualified Health Center
FUH	Follow-Up After Hospitalization (for mental illness)
FUH-7	Follow-up visits after hospitalization for mental illness in 7 days
FUH-30	Follow-up visits after hospitalization for mental illness in 30 days
GPP	Global Payment Program
HbA1C	Hemoglobin A1c
HCV	Housing Choice Vouchers
HEAP	Homeless Emergency Aid Program
HHP	Health Homes Program

HIE	Health information exchange
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMIS	Homeless Management Information System
HS	Housing Services
HUD	Housing and Urban Development
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IET-14	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment within 14 days
IET-30	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment within 30 days
IGTs	Intergovernmental transfers
IMAT	Integrated Medication Assisted Treatment
IPU	Inpatient Utilization
IT	Information Technology
LANES	Los Angeles Network for Enhanced Services
LE	Lead Entity
LEAD	Law Enforcement Assisted Diversion Program
LVN	Licensed vocational nurse
MA	Medical assistant
MCIEP	Medi-Cal Inmate Eligibility Program

MDD	Major Depressive Disorder
MDT	Multi-disciplinary team
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NP	Nurse practitioner
NPLH	No Place Like Home
NQF 0719	National Quality Forum for Children Who Receive Effective Care Coordination of Healthcare Services When Needed
OBH	Overall Beneficiary Health
OBH-O	Enrollees' Overall Health
OBH-E	Enrollees' Emotional/Mental Health
OBI	Office of Business Intelligence
PCD	Diabetes-Related Primary Care Visits
PCH	Hypertension-Related Primary Care Visits
PCMH	Patient centered medical home
PCP	Primary care physician
PDSA	Plan, do, study, act
PES	Psychiatric Emergency Services
PharmD	Doctor of Pharmacy
PH	Permanent Housing
PHI	Protected health information
PHQ	Patient Health Questionnaire

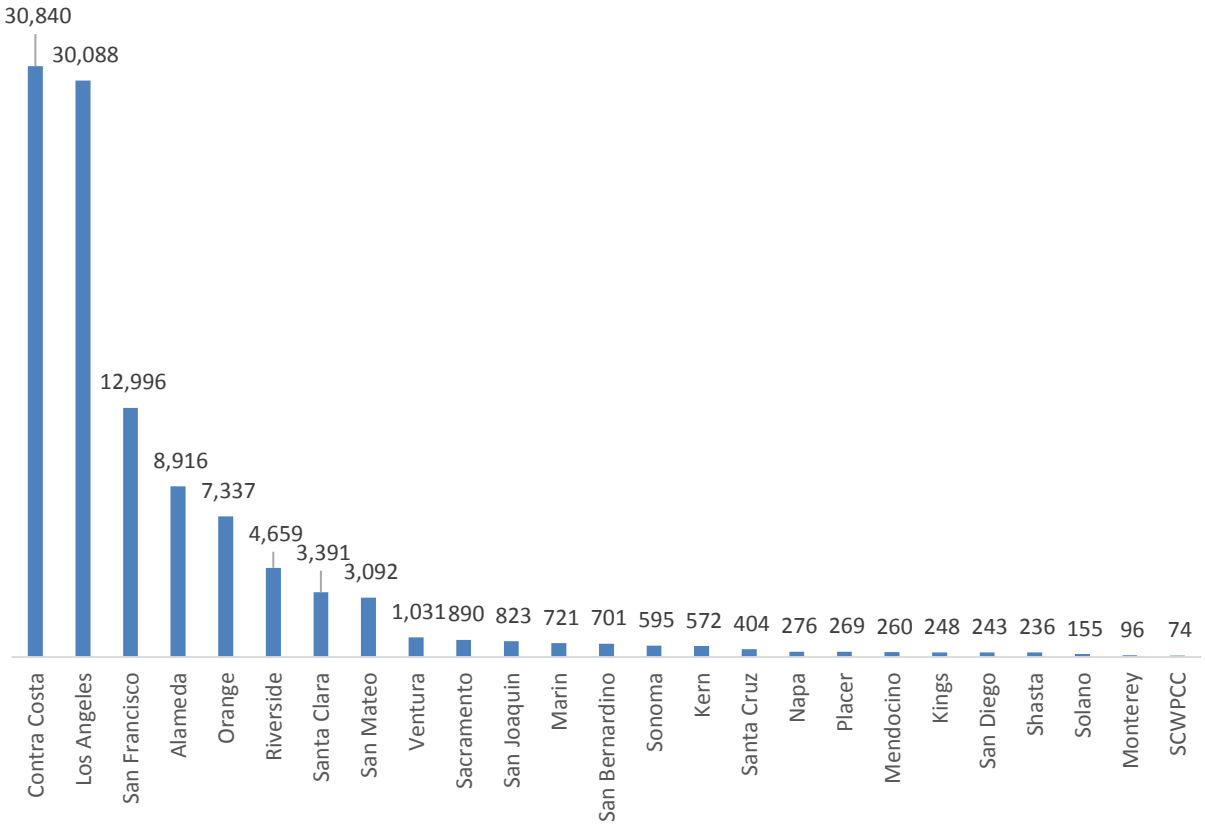
PHQ-9	Patient Health Questionnaire-9; Major Depressive Order of the full PQH
PHN	Public health nurse
PMPM	Per-member-per-month
PRIME	Public Hospital Redesign and Incentives in Medi-Cal, part of the 1115 waiver
PY	Program Years
P4O	Pay for outcomes
QI	Quality Improvement
RFP	Request for Proposals
RN	Registered Nurse
ROI	Release of Information
SB 1152	Senate Bill 1152
SCC	Small County Collaborative
SCP	Shared Care Plan
SH	Supportive Housing
SMI	Serious mental illness
SNI	Safety Net Institute
STCs	Special Terms and Conditions
SUD	Substance use disorder
TA	Technical Assistance
TOC	Transitions of Care

UCLA	University of California, Los Angeles, Center for Health Policy Research
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WAR	Whole Person Care Accountability Review
WIT	Waiver Integration Team
ZSFG	Zuckerberg San Francisco General

Appendix R: Enrollment Size by Pilot

Exhibit 1 shows total unduplicated WPC enrollment through PY 3 by Pilot. Enrollment ranged from 74 enrollees in the SCWPCC to 30,840 enrollees in Contra Costa. Of the 25 WPC Pilots, nine Pilots had enrollment numbers over 1,000 enrollees and nine Pilots had enrollment under 300 enrollees. Given the staggered implementation of the program, the length of time that each WPC Pilot was actively enrolling individuals into their Pilots varied.

Exhibit 1: Total Unduplicated Enrollment in WPC by Pilot, January 2017 to December 2018



Source: *Whole Person Care Enrollment and Utilization Reports*, January 2017-December 2018.
Notes: Includes 108,913 unique enrollment into a WPC Pilot. Excludes individuals who received outreach or other allowed WPC services but did not enroll. SCWPCC is the Small County Whole Person Care Collaborative.

Appendix S: Selected Illustrative Examples of WPC PDSAs Submitted by Category

WPC Selected Plan-Do-Study-Act (PDSA) Projects

Exhibit 1: Selected Illustrative Examples of WPC PDSAs Submitted by Category Type

PDSA Category Type	WPC Pilot	PDSA Name	Start Date	Length (Days)	Summary of PDSA
Ambulatory Care	Alameda	John George Psychiatric Emergency Services highest utilizers pilot	9/5/2017	360	Patients who presented to John George Psychiatric Emergency Services were linked to Whole Person Care services in order to reduce high utilization. Patients were transported to the TRUST clinic (providing integrated care) where they were connected to a social worker to address social support or physical health needs. Alameda aimed to have social workers discourage the need for high PES utilization. Results from the PDSA showed a decrease in average patient PES utilization.
	Contra Costa	Reduce ED utilization-implement EDIE software	2/1/2017	333	EDIE (Emergency Department Information Exchange) was implemented in Contra Costa in order to reduce emergency department utilization and improve coordination of care for patients. This software proved successful in allowing Contra Costa to share and receive real time ED utilization data and receive notifications when patients were visiting emergency departments across multiple health systems. The focus was on developing workflows to develop targeted outreach and interventions to populations utilizing multiple health systems in order to reduce future ED utilization and direct patients to the appropriate outpatient setting.
	Shasta	Health literacy	9/1/2017	576	Shasta considered a participant's health literacy with direct correlation to helping decrease unnecessary emergency department and inpatient visits. Some of the planned interventions for this PDSA project included: documenting and reporting health literacy knowledge of the participants, expecting WPC RN's and case managers to provide alternate support and education, and providing everyday

PDSA Category Type	WPC Pilot	PDSA Name	Start Date	Length (Days)	Summary of PDSA
					organizational items such as pill cases, wall calendars, and address books.
Care Coordination	Orange	Development of policies and procedures relating to care coordination, case management, and referral infrastructure	1/1/2017	545	In Orange there was no centralized process for care coordination including referrals, documenting, and linking to care management. The aim of this project was to draft policies and procedures for care coordination in the pilot. Some interventions taken were establishing subcommittees, establishing a centralized WPC website and portal for participants, and establishing a centralized communication point for input.
	San Mateo	Assignment of care coordinator	1/1/2017	455	This project aimed to assign more than half of WPC participants with a care coordinator by December 2020 in San Mateo. Some challenges noted through this project were lack of a consistent definition and policy regarding care coordinator, lack of consistent policy on the role and purpose of the client care plans, and the lack of risk stratification to manage caseload/panel size and complexity. This project was in the process of working to develop policies and procedures for care coordination, case management, and referral across the health system. This project also monitored health outcomes, addressed barriers and gaps by developing experiments, and mapped out existing care coordination programs.
	Riverside	Case management	6/1/2017	456	In Riverside, individuals with physical health diagnosis, severe mental health condition, and who were justice involved were connected to resources that assisted them in managing their care and reducing their reliance on the emergency department. In an effort to increase communication between different departments, this project coordinated periodic meetings between the detention health coordinator, behavioral health worker, and WPC care coordinator. WPC nurses used software, such as EPIC, to view the physical and behavioral health of individuals as they transitioned into the community from Riverside County jails.

PDSA Category Type	WPC Pilot	PDSA Name	Start Date	Length (Days)	Summary of PDSA
Comprehensive Care Plan	Monterey	How to transport wheelchair-bound WPC enrollees	7/6/2017	421	In Monterey County, ensuring that participants could make it to their scheduled appointments was part of their care plan. Some WPC enrollees were electric wheelchair-bound and although the county usually contracts a cab for wheelchair-bound enrollee transportation, electric wheelchairs are much heavier and cabs are not equipped to transport them. The county had a policy of only purchasing new vehicles and therefore the Pilot was in search of a van that met their needs and their budget of $60,000. In working with county fleet personnel, the pilot learned that the Behavioral Health Bureau had a van that met their exact needs. They then requested and were granted use of the van so they could transport these enrollees, thus reducing the number of missed health and social services appointments.
	Solano	Clients with comprehensive care plan within 30 days of enrollment	9/14/2017	567	With this project Solano aimed to complete comprehensive care plans for clients within 30 days of enrollment. Through the PDSA, a new care coordinator was hired which led to 87% of clients having care plans created within 30 days. Additional outreach and engagement efforts were also conducted for future potential enrollment.
	Ventura	Ensuring comprehensive care plan development	April 2017	762	The aim for this project was for comprehensive care plans to be accessible to at least 60% of newly enrolled participants within 30 days and to increase by at least 5% each year. With the implementation of this project, 84% of participants had comprehensive care plans completed within 30 days of enrollment. Care plans were expected to be accessible by all assigned providers and available within the WPC data sharing platform. The next steps for this project were for a WPC quality improvement coordinator to pull a twice monthly analysis of care plans, an updated care plan, track the care plan metric, and the medical director completing a chart review of every new case.
Data	Los Angeles	Enrollment data processing	11/1/2017	152	WPC- Los Angeles had 16 programs all collecting data using a different method. This project was implemented in an effort to improve the time for data collection and enrollment data preparation. A standard data entry tool was created and

PDSA Category Type	WPC Pilot	PDSA Name	Start Date	Length (Days)	Summary of PDSA
					program staff were trained in data submission standards and data quality standards by the Office of Planning and Data Analytics in order to standardize data collection. This effort resulted in less errors in client data and more consistent data collection across programs.
	Placer	WPC individual services tracking sheet data improvement	9/7/2017	207	Through this project, Solano aimed to improve the accuracy and exchange of data collection for individual services tracking. By initiating and communicating an improvement plan with involved staff and also requiring the analyst to review the tracking sheet twice a week, the project reduced errors by 40%.
	Santa Clara	Improve WPC patient identification: opt-out enrollment notification	6/1/2017	394	This project aimed to address enrollment gaps by focusing on the needs for procedure related enrollment letters, validation and approval of WPC enrollment lists. Data integration and communication leads met and drafted policies and procedures to be implemented during the next enrollment period.
Inpatient Utilization	San Bernardino	Inpatient utilization	3/7/2018	390	The intent of this project was to identify and reduce unnecessary inpatient utilization amongst WPC enrollees. The Pilot formed a quality improvement collaborative with partners and local hospitals. Partners were invited to attend monthly operations meetings in person or via phone. As a result, inpatient utilization decreased by 81%.
	Kings	Outreach to local hospital	1/15/2018	334	This project aimed to decrease inpatient admissions for patients experiencing a mental health crisis. This was implemented by establishing a partnership between WPC and the local hospitals. Staff were educated through presentations on how the Pilot could help decrease utilization and improve care coordination. The expectation was that WPC referral numbers would rise following these presentations and partnerships meetings.
	San Francisco	Reducing medical and psychiatric inpatient utilization among San Francisco homeless individuals	1/1/2018	820	This project hoped to reduce homeless related inpatient utilization by 5% annually. A journey mapping workshop was consolidated into a visual that presented opportunities and barriers identified by providers. Some initiatives surrounding care coordination that stood out to the WPC team were:

PDSA Category Type	WPC Pilot	PDSA Name	Start Date	Length (Days)	Summary of PDSA
					Social Medicine work at Zuckerburg San Francisco General (ZSFG), Hummingbird, Emergency Medical Services (Ems6), Medical Respite, and the Sobering Center.
Other	Kern	Administrative: data and information sharing infrastructure	July 2017	821	Through the implementation of Cerner, Kern hoped to strengthen data sharing capabilities with community based organizations, without compromising client privacy. Although tedious and time-consuming, the project did prove to be successful in manual data sharing with community based organizations after redaction medical information. Kern Medical expected to be able to provide unrestricted files such as client pedigree information, notes, and other social factors by 2018.
	Marin	457-INFO as a care coordination hub for Marin WPC	4/1/2018	364	Marin used the "457-INFO" Aging and Adult Services phone and email hotline as a Whole Person Care hub for care coordination. Some advantages of the services were that this service was staffed daily, could answer questions about public benefits, had access to MEDS (Medi-Cal Eligibility Data System) and other databases, and offered trusted resources for community. With training, 457-INFO staff were able to schedule entry assessments, administer WPC release of information, and check and update public benefits for WPC enrollees.
	San Joaquin	Reduce incarceration	January 2018	456	The WPC administrative team engaged San Joaquin County partners (e.g., Forensic Behavioral Health Staff, San Joaquin County Public Defender's Office, San Joaquin County District Attorney's Office, and the San Joaquin County Correctional Health Staff) in order to discuss existing and upcoming programs. The WPC team focused on how to reduce incarceration by trying to identify why individuals return to jail. The project allowed for the creation of a process and outlined procedures for a WPC referral to occur when a participant is processed into County jail.

Source: Program Year 2 Mid-Year, Program Year 2 Annual, Program Year 3 Mid-Year, and Program Year 3 Annual PDSA Reports (n=25)